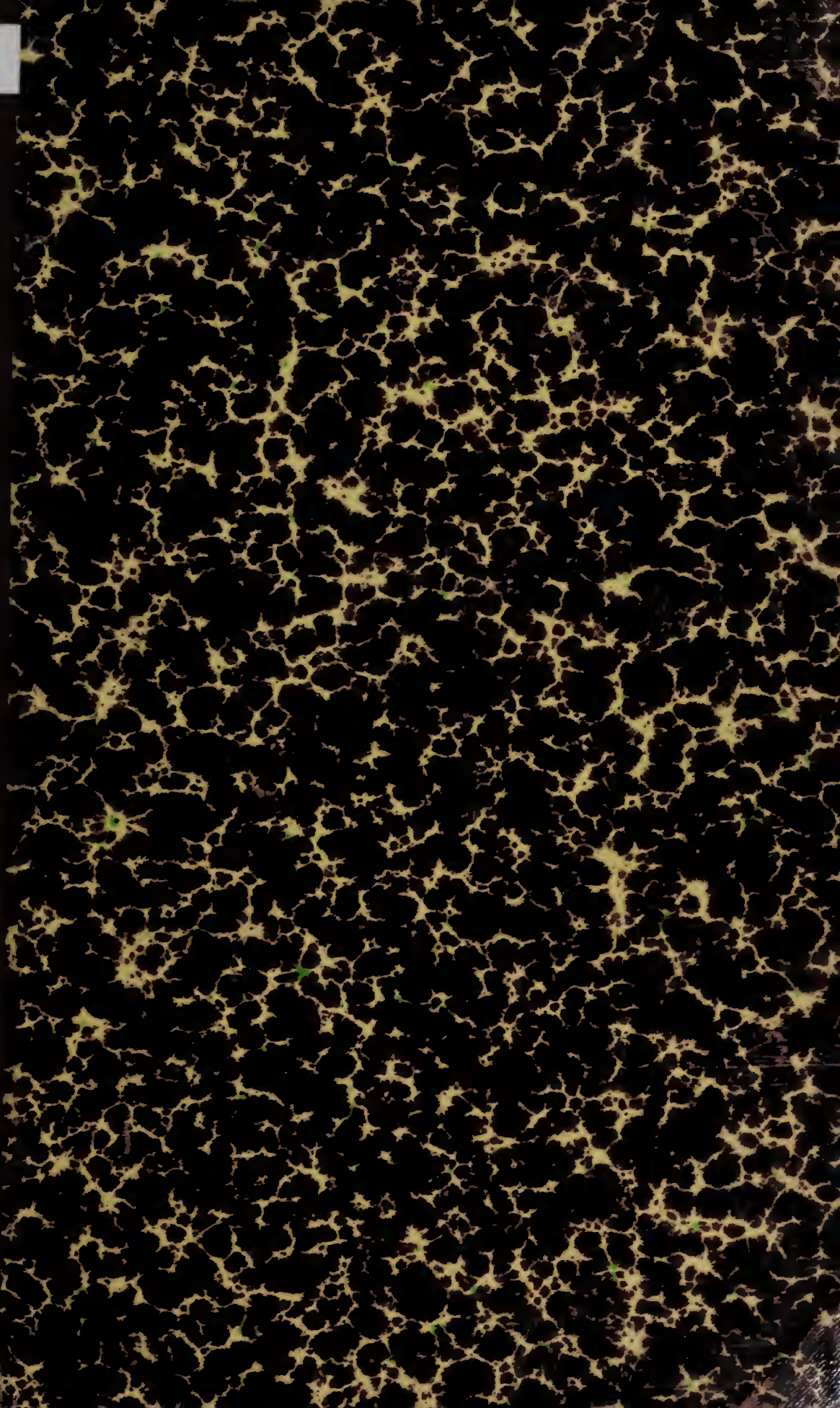



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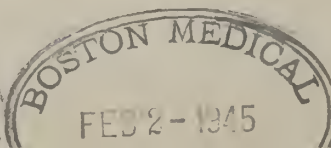
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THE PREVENTION AND CONTROL OF SURGICAL INFECTIONS IN A GENERAL HOSPITAL*

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Chicago, Illinois

Some years ago while working on a surgical service in a large general hospital I returned from a vacation to find five hernia patients with infected operative wounds. Our record had been so excellent as far as postoperative infection was concerned that I asked the interns if they had any explanation for this "epidemic." They had none. I asked, "Did you cover your noses with your masks while you were in the operating room?"

"No," they said, "the surgeon who took your place thought that was unnecessary."

"Did you clip sterile towels to the wound edges after making the skin incision?"

"No," they said, "the surgeon wouldn't wait for us to do that."

I might have asked a number of other equally pertinent questions and probably would have received equally discouraging answers. The point is that the prevention of surgical infection involves consistent and meticulous attention to many apparently trivial details and neglect of any one of them may result in the infection that jeopardizes the success of the operation, the patient's pocket book, perhaps his future well being and comfort and even his life.

Time does not permit nor is it in my province to discuss all the possible sources of wound infection. For the sterilization of dressings, gauze, linen, surgical instruments and solutions we have come to depend upon our unseen helpers—the surgical nurses, who spend many weary and anxious hours so that everything shall be in readiness at the hour appointed for operation. We are inclined to forget what ardu-

ous and devoted service they render; and I should like to record my belief that if every surgeon, young or old, were as patient, as conscientious and faithful in carrying out the many time-consuming details involved in adequate preparation, careful operative technique and thoughtful postoperative care as are surgical nurses in the performance of their routine tasks surgical infections could be almost completely eliminated.

I wish to discuss briefly the important potential sources of infection, and indicate methods that have been found most helpful in combatting them. In order of their importance these sources are: the operating room personnel; visitors and students; the patient's skin; suture material; dressings, supplies and solutions.

OPERATING ROOM PERSONNEL

Today we look aghast at the picture of the distinguished Samuel Gross, dressed in frock coat and black trousers, taking the scalpel from the wooden box on the table beside him and cutting into the unbroken skin of the patient lying before him. Ten years from now our successors will be just as startled at our not infrequent failure to protect the surgical patient from the virulent bacteria that constantly lurk in the human mouth and nose. That these bacteria are deadly and virulent is attested by the serious character of the so called human bite infections. None of you who has treated a hand or other part of the body which has been infected by direct contact with human teeth but will agree as to the serious character of the infection and the difficulty with which it is brought under control. That virulent bacteria have their habitat in the human mouth and nose we all agree. That they can be transmitted to an open wound and cause virulent infection no one doubts. That such transmission can be prevented by the simple expedient of wearing a suitable mask over mouth and nose has been demonstrated over and over again.

The logical child of ten years would say, "If you know the danger exists, and you know how to prevent the infection, of course you do the thing that prevents it."

But do we?

*Presented at the 82nd Annual Session of The Kansas Medical Society, Topeka, May 14, 1941.

**From the Department of Surgery, Northwestern University Medical School.

A few years ago I went to a southern Illinois city to see a doctor's wife who had developed a serious infection of the hand. The infection had become localized in the tendon sheaths of thumb and little finger and it seemed wise to drain the affected sheaths. After changing clothes, masking my face and scrubbing my hands for ten minutes I went into the operating room. The patient lay on the table with face uncovered. The instrument nurse had a mask over her mouth, not her nose. The anesthetist had nothing over her head to hide her permanent wave; no sign of covering over her face except her brightly colored cosmetics. The operating room supervisor walked in and out with a tiny starched cap pinned over the back of the head. A doctor friend, dressed in his street clothes, walked in to give a cheery greeting to the waiting patient. After a few moments I called the supervisor to one side and told her as briefly as I could the story of Meleney and Stevens' work in tracing the source of hemolytic streptococcic infections that developed in a group of clean surgical cases, and their practical conclusion that when everyone who entered the operating room, including nurses, orderlies and visitors, were carefully masked infections due to the hemolytic streptococcus practically disappeared. The swinging doors leading to the operating room were closed, and shortly afterward everyone, including the anesthetist and the patient, was masked.

Not long ago I saw the doctor and his wife, the patient. I wanted to ask whether my suggestions had had any lasting effect, but simply asked how things were at the hospital. He said, "Fine! we have a new surgical wing since you visited us." Many hospitals, however, need not so much new wings as a new surgical conscience and a new determination not to ignore the smallest detail that will contribute to prevention of infection and healing of operative wounds by primary union.

Of equal importance with careful masking in the prevention of infection of the operative wound is the routine examination of operating room personnel. By making cultures of the nose and throat of surgeons, house officers, nurses and orderlies, and particularly during the winter months when the number of healthy "carriers" reaches its highest level (Hare², Meleney⁶) we can eliminate an important source of air borne infection, and so minimize the likelihood of contamination of open wounds. Recently on our own service we had to go shorthanded for a month and deprive one of our staff of the opportunity of working in the operating room until he could get rid of streptococci which he was harboring as a carrier in his throat.

It is not enough to guard against infection in the

operating room. The patient with a large open wound can be easily infected and reinfected when dressings are changed. In no cases is this more important than in patients with extensive burns. Recently when asked to see such a case one of the doctors in attendance asked, "Is it true that every patient with an extensive burn inevitably develops a blood stream infection?" I had never heard such an idea expressed before, but it doubtless was prompted by past experience or observation. If you were to ask any medical student why the surgeon in the operating room and his assistants and nurses mask their faces he would have a prompt answer. If you were to ask him why one rarely sees surgeons and nurses with faces masked as they care for wounds, perhaps far more extensive, outside the operating room what would he say?

VISITORS AND STUDENTS

The same care in masking must be exerted by everyone who enters the operating room, including orderlies, students and visitors. It is because of the danger of air borne infection from uncovered faces that we are reluctant to carry out surgical procedures before a large group, whether students or visitors, and that we are insistent that every visitor present should be masked as carefully as the surgeon. Moreover it is obviously inconsistent for men in the gallery or visitors' seats to talk and laugh with uncovered faces, and then draw a mask over the face when the patient is brought in or when the operation is begun. Some of you will say we are unnecessarily "fussy," but if you have ever battled for weeks to bring under control a spreading streptococcus infection in someone very close and dear to you, an infection that you felt morally certain resulted from the presence of a visitor who was a streptococcus carrier, you will agree that no one can be too careful about enforcing rules that help to avoid such catastrophes.

THE PATIENT'S SKIN

The problem of "sterilizing" the skin before operation has been a subject of concern and discussion for many years. It is interesting to look back for a moment to a paper published in 1892 and describing the method carried out in Dr. W. S. Halsted's clinic¹ and to wonder at the fact that a surgeon whose first concern was care and gentleness in handling tissues would permit the use of a method of skin preparation that was so inconsistent with his avowed principles of surgical technique.

"About eighteen hours before the operation the part to be operated upon is shaved if necessary and covered with a huge poultice of green soap. Three hours before the operation the soap is thoroughly washed off in a bath of hot water and the skin of the patient is vigorously scrubbed. An astonishing

amount of desiccated epithelium is scrubbed off with the soap. A large wet gauze dressing is then applied. This dressing is then irrigated from time to time for an hour with a solution of corbolic acid, 1-30, and thereafter up to the time of the operation with a solution of corrosive sublimate, 1-1000. On the operating table the part to be operated upon is scrubbed and washed for a few minutes with a hot solution of corrosive sublimate, 1-100."

I shall not attempt to trace the numerous changes, advances and recessions that have been made with reference to the preparation of the patient's skin in the years that have intervened since Halsted's paper¹ was published, but repeat simply what is common knowledge to all of you:

(1) That with a realization of the fact that powerful chemicals injure body tissues just as quickly as they injure bacteria methods of so called chemical sterilization of skin have become constantly less drastic.

(2) That in spite of every effort made to sterilize the skin with various chemical antiseptics bacteria can be constantly found in the washings from clean surgical wound (Ives and Hirshfield³), and

(3) That it seems obvious that our chief defense against wound infection lies in simple surgical cleanliness and in handling tissues with gentleness and care so as to preserve the defensive mechanism against infection which man has developed during many centuries of struggling for existence.

Our insistence upon the preparation of the field of operation with plain white soap applied with sterile cotton and gloved hands is in no sense an original contribution to surgical technique, though it is the result of our own observations and our own experience. I do not say this with pride but rather with regret that we had to prove to ourselves by tedious clinical experiment what study of the writings of others and simple logic should have made obvious long ago.

Briefly, the use of soap and water alone to prepare the field of operation resulted first from observations of war wounds which were treated without antiseptic applications; and secondly from observation of the improved results obtained in the treatment of compound injuries as the use of antiseptics in pre-operative preparation was gradually eliminated. Eventually we came to use nothing but soap and water in the preparation of patients with compound wounds, and the incidence of healing by primary union and without suppuration and sinus formation steadily increased. From that point it was a logical step to the preparation of surgical patients without open wounds by the same method, and since 1935 we have employed only soap and water in the prepa-

ration of all surgical patient except thyroid patients, in whom conservation of every moment of time is an important factor, and patients with a small localized lesion such as a small sebaceous cyst or a papilloma.

A few years ago with the aid of Drs. Thomas Douglass and Harvey S. Allen we made a survey covering a period of ten years at Passavant Memorial Hospital, and noted the incidence of primary union in every clean case operated upon on the services of Drs. Kanavel, Michael Mason and myself, and on a second surgical service in which tincture of iodine was used routinely in preparation of the field of operation. As a criterion of healing by primary union we stated that the dressing removed at the second change of dressings must be free from any stain or discoloration. (Invariably at the first change of dressings there will be discoloration from dried blood no matter what the character of wound healing.) Even a small amount of serous discharge was considered as indicating failure of healing by primary union; and cases with hematoma formation were also so considered, even if in such cases no evidence of infection was obtained. Some of the results of this survey are shown in (Table I).

TABLE I

Fifteen hundred consecutive surgical cases, closed without drainage.

Preparation of Operative Field	No. of Cases	No. Healing by Primary Union	Percent
Iodine and alcohol	717	635	88.56
Picric acid 5% in 50% alcohol..	516	465	90.0
Soap and water.....	267	245	91.76

Seventy-six Cases of Hernia

Iodine and alcohol	48	43	89.6
Picric acid	17	17	100.0
Soap and water.....	11	11	100.0

One Hundred and Twenty-three Cases of Breast Tumor

Iodine and alcohol	35	28	80.0
Picric acid	61	52	85.2
Soap and water.....	27	25	92.6

Eighty Cases of Cholecystectomy, Closed Without Drainage

Iodine and alcohol	66	58	87.9
Picric acid	11	10	90.9
Soap and water.....	3	3	100.0

One Hundred and Eighty-eight Cases of Nerve and Tendon Repair*

Iodine and alcohol	3	3	100.0
Picric acid	133	119	89.5
Soap and water.....	52	50	96.1

* This group of cases is of particular interest because the operations were unusually long and tedious, invariably required two hours, and often more.

Subsequently, in connection with a study of all cases of appendicitis operated upon at the hospital from the date of its opening, June 10, 1929, to January 1, 1940, a record was made as to the relation of primary wound healing and the type of pre-operative preparation employed (Table II).

TABLE II

Eight hundred and seventy-nine cases of appendicitis, closed without drainage, from all services at Passavant Memorial Hospital.

Preparation of Operative Field	No. of Cases	No. Healing by Primary Union	Percent
No record	42	40	.....
Iodine and alcohol	428	415	96.96
Ether, iodine and alcohol	35	34	97.1
Picric acid	193	191	98.96
Soap and water.....	181	180	99.44

In the years that have intervened since the first study was completed the results have been still better; and the results obtained with soap and water preparation alone at the Cook County Hospital were sufficiently impressive to lead to a general order that without prejudice to other methods of preparation the use of soap and water must be included in the preoperative preparation of all surgical patients.

SUTURE MATERIAL

The question as to the most satisfactory suture material is a highly controversial one and without embarking on an extended discussion of the advantages of various types of suture material. I would simply say that for more than five years we have used only silk except in a few cases of appendicitis with localized peritonitis. We have not used catgut in any clean cases or in any cases of compound injury in which wound closure has been carried out. This period in which silk has been used to the exclusion of other types of suture material corresponds closely to the period in which wound preparation has been confined to the use of soap and water.

So many papers devoted to the subject of suture material have appeared in recent years that you are all familiar with the pros and cons. I would only recall to your attention the fact that catgut is an organic foreign substance, that it is absorbed by a process of liquefaction necrosis, and that the larger the size of the catgut the more intense is the foreign body reaction that results from burying it in the body tissues. This explains the paradoxical fact that the larger the size of the catgut the more quickly does it disintegrate and the more likely is it to give way when used to approximate tissues under tension.

One very simple observation stands out sharply in my memory. When it was our custom to suture the platysma with fine catgut sutures as one of the steps in wound closure after thyroidectomy it not infrequently happened that four, five or six days after operation a few small cyanotic areas would appear along the line of closure, and after another few days it would be obvious that small subcutaneous collections of fluid had formed. When these were opened with a sharply pointed knife a few drops of turbid fluid would escape and with it a tiny knot of catgut. Since adopting silk for suture material we

have never seen such an accident occur. On a number of occasions we have seen knots of black silk placed in the fascia of the forearm, for example, begin to show through the skin and attract the attention of the patient, and in such cases I have nicked the skin over these knots and removed them, but I have never seen a drop of fluid or of pus form around such a knot.

There is abundance of experimental evidence to show how extensive and intense is the inflammatory reaction around catgut sutures and ligatures as compared with silk. Whipple's excellent paper on the use of silk in clean wounds depicts very clearly the comparative reaction to silk and catgut in parallel wounds in the same animal.

It is possible that cotton and stainless steel wire may have advantages that silk does not possess. Our own experience with silk has been so satisfactory that at present we are unwilling to substitute any other suture material. We shall watch with interest, however, the results obtained with other methods, and not be the last "to throw the old aside."

A word should be added about the difficulty of insuring the absolute sterility of catgut. You are all familiar with the efforts that have been made under the leadership of committees of the American College of Surgeons and the American Surgical Association to secure rigid standardization of methods of sterilizing catgut. Every surgeon who uses catgut is indebted to these committees, and particularly to Meleney of New York, for the improvement in standards that has gradually been secured and for the almost complete elimination of incompletely sterilized catgut from the market.

DRESSINGS, SUPPLIES AND SOLUTIONS

Concerning the possibility of wound infection resulting from nonsterile gauze, linen and solutions I would only say that in every case that has come to my attention in which an effort was made to trace the source of wound infection, the checking of the supplies used in the operating room and of methods of sterilizing those supplies showed negative results. In other words, contamination of the operating room supplies was never demonstrated.

Again, we must pay tribute to the constant watchfulness and persistent attention to details by the operating room nurses and engineering staff that make it possible to carry out day after day the sterilization of large quantities of gauze, linen and surgical instruments, and without permitting a break in the routine that could so easily lead to disaster.

THE CONTROL OF INFECTIONS

Once infection has developed in a surgical case our first problem is one of diagnosis. Too often we fall

into the error of treating the infection first and making the diagnosis only when treatment fails.

We must ask ourselves: First, is the infection an acute rapidly spreading infection, or is it localized? Second, if it is localized in what anatomical planes or structures has it localized? Third, what is the character and type of the causative organism?

In the presence of an acute spreading infection it may not be possible to determine immediately the causative organism, but it is important to recognize the fact that one is dealing with a diffuse rapidly spreading infection in cellular tissue, and not to hasten its spread and jeopardize the patient's life by ill advised exploratory incisions. High fever, sometimes with chills, prostration, diffuse pain, tenderness and induration, a red blush and red streaks extending proximalward from the site of maximum involvement—all speak for a virulent spreading infection that demands conservative treatment and abstinence from surgical incision. If a low or falling leucocyte count is present, the prognosis is grave.

Massive warm wet dressings to aid in bringing about localization, absolute rest, one or two x-ray treatments that combined fall short of an erythema dose, and maximum intake of fluid to dilute toxins and provide maximum elimination are all of importance. The addition of chemotherapy has been of invaluable aid in the treatment of this type of infection, and we are gradually learning how the sulfonamides can be employed to greatest advantage.

It is hardly necessary to say that we cannot abandon methods that have stood the test of time, and place all our reliance on chemotherapy if we are to secure the best results. Certain types of infection are not susceptible to sulfanilamide and its derivatives. Certain individuals, as Dr. Toomey has told you, cannot tolerate these drugs and may rapidly develop toxic symptoms from their administration. Lyons⁴ of Boston has shown that in certain individuals the phagocytic activity of the leucocytes is low and that in such a case the transfusion of blood from an individual who has had even a mild streptococcus infection can stimulate phagocytic activity and prove a life saving measure. It is the patient who cannot tolerate sulfanilamide, and who has no immunity to the streptococcus who provides the most difficult problem we have to face.

In the presence of a localized infection adequate incision, drainage, and cleanly surgical care that does not permit adding further infection to the open wound are measures that rest on established surgical principles. The most ardent advocates of chemotherapy emphasize the fact that it can accomplish little if an undrained localized accumulation of pus is present.

With reference to the question of exact bacteriological diagnosis I am sure we have all been too remiss. Because the common types of pathogenic organisms tend to disappear rather rapidly if an infected wound is given cleanly surgical care, if one does not add further infection and traumatize the living tissues we may forget that certain types of infection demand a specific type of treatment if the infection is to be brought under control in the minimum period of time.

There are three types of infection in particular that are often unrecognized and so lead to long delayed healing or fail completely to respond to treatment:

1. Infections due to the anaerobic hemolytic streptococcus—the microaerophilic streptococcus of Meleney.

2. Infections due to a symbiosis of organisms, typified by the synergistic gangrene resulting from a combination of the hemolytic staphylococcus and the nonhemolytic streptococcus. This has also been well described by Meleney⁶.

3. Infections in which the spirocheta pallidum has been inoculated with pyogenic organisms and remains long unsuspected as the major cause of trouble.

An accurate diagnosis as to the exact nature of the infection is the first logical step to make toward bringing such infections under control. If an infected wound does not show prompt improvement with simple cleanly surgical care cultures should be made of the wound secretion on both aerobic and anaerobic media. Once the exact nature of the infection is determined treatment becomes a matter of scientific accuracy rather than of uncertainty. As far as actual treatment of these types of infection is concerned it is not necessary to repeat facts which are familiar to all of you.

In closing one cannot stress too strongly that the most important principle in the care of every infected wound is not to add further infection to that which is already present. Masked faces, sterile instruments, surgical cleanliness, gloved hands are important—and most important of all is a serious determination not to omit any detail of cleanly care that will help to hasten recovery.

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RECOGNITION AND TREATMENT OF CURABLE DISEASES OF THE HEART*

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Treatment in most diseases of the heart concerns itself not so much with cure but with measures directed at correcting the disturbed physiology resulting from the disease. Thus the abnormal state of circulation may be brought to a nearly normal condition in spite of the inability to eliminate or arrest the underlying cardiac abnormality. Such management when successful enables the patient to feel well, and symptoms do not appear with ordinary activity though the structural changes due to the disease still exist within the heart.

Much has been said and written about the more common organic diseases of the heart from which complete recovery is rare. In most instances a diagnosis is made of arteriosclerotic, hypertensive, rheumatic or syphilitic heart disease, and little recognition is given to the less common diseases of the heart, a large number of which are now completely curable.

It is the purpose of this paper to present a discussion of the recognition and treatment of a group of disorders of the heart in which the disease processes and the mechanical defects can be abolished or corrected. To forms of heart disease that fulfill these requirements the term "curable" may properly be applied. The conditions to be described all represent diseases of the heart in which complete recovery may be expected, provided they are promptly recognized, and treatment instituted early before irreversible change occurs. A few of these conditions are newly discovered disorders of the cardiovascular system. Some represent cardiac diseases well recognized by the profession for years, but unfortunately too often overlooked by the examining physician. In others recent advances in the medical and surgical treatment of heart disease have made it possible to bring about a cure in certain conditions formerly classed as incurable.

It is hoped that a brief description of the signs,

symptoms, pathological physiology and laboratory findings in these curable forms of heart disease will be of help to others in recognizing these conditions with increasing frequency.

MYXEDEMA HEART

Myxedema heart disease is an excellent example of a cardiac condition in which a permanent cure can always be predicted. Unfortunately the diseases, myxedema and myxedema heart, are diagnoses frequently overlooked even in typical cases where hypothyroidism is fully developed. When the heart is involved in the myxedema patient, the clinical manifestations are chiefly those of some degree of congestive failure which does not respond to digitalis or other cardiovascular drugs.

The disease may be recognized at once by the peculiar alterations of the skin, the slow monotonous speech, the memory changes and the paraesthesias of the extremities. The basal metabolic rate is usually quite low, with determinations of as low as minus thirty per cent or lower. Hypercholesteremia is always present, with blood cholesterol values ranging from 250 to 400 mg. per cent. The heart is enlarged, the heart sounds muffled, and there is oftentimes a systolic apical murmur present. The blood pressure is usually low and the pulse slow. The electrocardiographic findings are fairly characteristic with low electromotive force in all complexes with flat or inverted T deflections in one or several leads.

The administration of thyroid extract produces striking changes in the hearts of these patients. The condition has oftentimes been referred to as the accordion or reversible heart, because with thyroid extract therapy the heart becomes smaller in size; when therapy is discontinued, the heart again enlarges. With adequate thyroid administration all signs and symptoms of the disease disappear and the electrocardiogram returns to normal. It is now the general opinion that at least a part of the enlargement of the heart is due to pericardial effusion. The myocardial changes are completely reversible.

A word of caution should be given in the treatment of this condition in patients of the older age group who have an associated coronary or cerebral arteriosclerosis. Especially in elderly myxedemas of long standing the sudden acceleration of the metabolism by treatment with thyroid extract may place too great a strain on the cardiovascular system and fatal cerebral and coronary accidents may occur. Bartels and Bell¹ have recently emphasized this danger.

THYROTOXIC HEART

This condition is brought about by the increased demands placed on the heart by a state of hyper-

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thyroidism. The increased blood volume, the peripheral vascular dilatation and the accelerated blood flow, all afford proof of the increased load carried by the thyrotoxic heart. It is often referred to as the "goitre heart" and tends to occur most commonly in patients over forty years of age with already slightly damaged hearts. The thyroid enlargement is usually of the nodular adenomatous type. Oftentimes little evidence of typical hyperthyroidism presents itself clinically, the hyperthyroidism in these instances being masked by predominating symptoms of the associated heart disease. The condition of thyrotoxic heart should be suspected when tachycardia and irregularities of the pulse do not respond as well as expected to digitalization in a patient with congestive failure. Early in thyrotoxicosis the tachycardia is not associated with cardiac enlargement, murmurs or evidence of decompensation. Extrasystolic arrhythmias appear rather frequently. Auricular flutter and bundle branch block are seen only occasionally. Later, auricular fibrillation appears and if uncontrolled, is a big factor in leading to cardiac dilatation and congestive failure. After cardiac dilatation takes place, apical systolic murmurs become evident, the heart sounds become loud and snappy in character—the apex beat abrupt and forceful. The basal metabolic rate is usually increased; however, this is not an uncommon finding in congestive failure from any cause. In the more advanced case the patient may exhibit all the signs and symptoms of right-sided heart failure with enlarged liver, ascites and dependent edema.

The treatment is surgical removal of the thyroid gland after adequate preoperative preparation with Lugol's, digitalis, sedatives and bed rest. If the thyrotoxicosis is ended successfully, the thyrotoxic heart returns to the condition it presented before hyperthyroidism occurred. This in most instances means a heart that, although slightly damaged, is now, without the additional load, capable of carrying on satisfactorily without further medication.

BERIBERI HEART DISEASE

The disease beriberi and beriberi heart disease are both result of thiamin (Vitamin B₁) deficiency. This abnormal condition is brought about by either a deficient thiamin intake in the diet or by increased Vitamin B₁ demands of the body. Frequently both these factors operate to produce the deficiency state. Beriberi heart disease when present is not an easily recognized clinical syndrome. The diagnosis depends chiefly on the dietary history. Cardiac symptoms without known etiologic cause, especially in a patient with clinical manifestations of other vitamin deficiencies, should lead one to suspect multiple deficiency disease, and in all probability beriberi heart

disease. Some of the symptoms most frequently encountered are dyspnea, palpitation, tachycardia, weakness, anorexia, some degree of peripheral neuritis and a sense of constriction in the mid-epigastric region. The heart is usually enlarged, but may be normal in size. There is characteristically an increased pulse pressure and other physical signs of peripheral vascular dilatation such as is seen in hyperthyroidism; however the basal metabolism is usually below normal in beriberi. In advanced cases severe right-sided failure with dependent edema may predominate the picture. The electrocardiogram is not characteristic, showing deflections of low electromotive force and T wave changes varying from flatness to inversion. The tracing may be entirely normal. There is peculiarly an accelerated circulation time in this condition not present in any other types of cardiac failure.

The response to adequate Vitamin B₁ therapy is dramatic and striking. The cardiovascular changes, including the hydropic degenerated myocardial fibers are all completely reversible. The edema when present rapidly disappears accompanied by generous diuresis. The heart if dilated returns to its normal size. Electrocardiographic changes revert back to the normal. The thiamin therapy is best given parenterally in doses of fifteen to thirty mgs. three times a day together with other vitamins if associated deficiencies exist. It is well to bear in mind that beriberi may be superimposed on other types of heart disease, especially in those cases where congestive failure is associated with anorexia and other gastro-intestinal disturbances. Supplemental treatment with Vitamin B₁ in these cases removes the added burden placed on the heart by the vitamin deficiency, thereby facilitating a more rapid recovery.

CHRONIC CONSTRICTIVE PERICARDITIS

A serious condition of the heart, oftentimes overlooked, is chronic constrictive pericarditis. This is a disorder of the heart in which there is an interference in the diastolic filling and contraction of this organ, the result of compression by a thickened adherent pericardium. The disease occurs more commonly in children and young adults and nearly always follows an acute pericarditis in from a few weeks to several years.

The symptoms are unimportant at first but may soon lead to weakness and semi-invalidism if the condition of compression is not relieved. The chronic compression due to the adherent pericardium leads to disuse atrophy of the myocardium, decrease in cardiac output, interference in filling of the heart chambers and marked peripheral venous congestion.

In chronic constrictive pericarditis the heart is small and quiet. The signs of increased systemic

venous pressure consist of engorged veins in the head and neck, enlarged liver, ascites, and fluid in the pleural cavity. There is low pulse pressure, tachycardia and oftentimes a pulsus paradoxicus. Fluoroscopy of the heart may reveal a lack of pulsation along the heart borders and some fixation of the heart and mediastinum. Radiographs show presence of a calcified pericardium in about one-third of the cases, and when present is almost pathognomonic of this disease. The electrocardiogram may show low voltage and slurring of the QRS group and T deflections in leads I and II of the coronary type.

Treatment by pericardiectomy, in skilled hands, has proven quite successful in recent years. The adherent pericardium and constricting bands are resected away from the heart, releasing the compression over the ventricles and vena cavae. Following the operation the heart dilates, and recovers from its atrophic condition. There is an increase in cardiac output and a marked drop in venous pressure. Diuresis is prompt and the signs of venous congestion clear up rapidly. Recovery is complete and permanent.

PATENT DUCTUS ARTERIOSUS

In the fetus the blood pumped into the pulmonary artery is shunted through the ductus into the aorta, the lungs being nonfunctioning. At birth the ductus normally closes. Rarely there is a failure of closure and the ductus remains patent throughout life. Patent ductus arteriosus is the third most common congenital cardiovascular abnormality. When present, the flow of blood in the ductus is from the aorta into the pulmonary artery. This shunting of blood back into the pulmonary artery places an added burden on the heart, and should the volume of blood shunted be great, the additional load on the heart is often sufficient to produce cardiac enlargement, congestive failure, and death at an early age. In addition, subacute endarteritis develops as a complication in twenty-five per cent of the cases. Recently successful closure of this abnormal channel has been effected by simple ligation.

The patient with this condition shows signs of retardation of growth and shortness of breath. Cyanosis is always absent unless the ductus is associated with other congenital cardiac anomalies. The physical findings of uncomplicated patent ductus arteriosus are quite characteristic. There is a loud continuous "machinery" murmur with systolic accentuation and palpable thrill over the pulmonary area. Increased pulmonary congestion, low diastolic and high pulse pressure are almost constant findings. On fluoroscopy one may see evidence of dilatation of the pulmonary conus and marked increase in pulsation of the pulmonary artery. The electrocardiogram

may show only left axis deviation.

The response to surgical ligation of the ductus is most gratifying. Gross and Hubbard² in 1939 reported the first successful ligation of a patent ductus on a girl seven and one-half years of age. Since then Jones³ and others have performed the operation on quite a number of cases with highly successful results. The operation restores the circulatory dynamics and prevents subacute bacterial endarteritis. Retardation of growth, evidence of cardiac insufficiency and peripheral signs of a shunting of blood of considerable magnitude are indications for operation. Contraindication for ligation is the presence of cyanosis, presence of this sign being strong evidence that other congenital cardiac anomalies coexist.

SUBACUTE BACTERIAL ENDARTERITIS IN PATENT DUCTUS ARTERIOSUS

This grave complication is recognized by the usual signs and symptoms of a patent ductus plus superimposed infection, positive blood culture for streptococcus viridans, embolic phenomena, anemia, etc. There are usually small implantations of organisms at the site of the congenital abnormality. Most frequently these vegetations are located at the pulmonary orifice of the ductus and in the channel, but may extend on down as far as the pulmonary valve. Since surgical ligation of both ends of the ductus has been successful in effecting a cure in this condition, cases should be recognized early before vegetations start to scatter down the wall of the pulmonary artery, and before the invaded areas become too friable for successful ligation. Tauroff, in 1940, was the first to successfully treat this condition. Since then he and others have reported other successes in the treatment of this formerly fatal disorder.

TRAUMATIC HEART DISEASE

In recent years increasing attention is being paid to traumatic injuries of the heart. The lives now saved by thoracic surgery in these injuries presents a dramatic story in medicine. In most instances the trauma to the heart results from penetrating wounds or blunt direct violence to the thorax. The effects of either type of injury produce hemorrhage into the pericardial space and acute cardiac compression or tamponade. If the abnormal circulatory dynamics is not promptly relieved, death ensues within a few minutes or hours. Contusion of the heart from direct violence is the most common form of trauma. The "steering wheel injury," "golf ball injury," crushing and cave in injuries are among the most frequent types of contusion to the chest and may result in partial or complete rupture of the myocardium, pericardial tears, ruptured auricles, subpericardial hemorrhage and hemopericardium. It is a well known fact that fatal contusion of the heart may occur without

apparent evidence of trauma to the chest wall or fracture of the sternum. Thus some contusions may entirely escape the attention of the unwary examiner.

The physical findings in cases of cardiac trauma are chiefly those due to the sudden accumulation of blood in the nonelastic pericardial sac. The resulting increase in intra-pericardial pressure produces the effects of tamponade with compression of the ventricles and thin-walled auricles and vena cavae. The cardiac output is markedly decreased, the venous return to the heart is obstructed, giving rise to a falling arterial pressure and a marked increase in the venous pressure. On auscultation the heart is usually quiet, and there may be a demonstrable increase in the area of cardiac dullness. Frequently in taking the blood pressure a paradoxical pulse can be demonstrated and when present should give one an immediate clue as to the nature of the circulatory disturbance. The electrocardiographic findings in contusion of the heart closely resemble those of myocardial infarction and pericarditis.

The treatment of these injuries by surgical repair of the damaged tissue has resulted in the saving of many lives. The condition is always an emergency. As soon as recognized, the nonclotted blood should be aspirated to relieve the cardiac compression and intravenous glucose solutions given while preparing the patient for surgery. These preparatory measures in themselves can be life-saving, although in most cases surgical removal of the clotted blood and repair of the myocardial injury is indicated provided the condition of the patient permits.

ARTERIOVENOUS FISTULA

Arteriovenous communication if of sufficient size, can lead to embarrassment of the heart and eventually to cardiac failure. These vascular fistulae may be congenital or acquired. The acquired form is usually the result of a gun-shot injury to large vessels in the femoral or popliteal region of the leg. The effects of this abnormal communication on the heart are due to the reduced peripheral vascular resistance. The resulting increased venous return and increased cardiac output over a period of time leads to overwork of the heart, hypertrophy of the myocardium and congestive heart failure.

Patients with arteriovenous fistula suffer from intermittent claudication and swelling of the extremity affected. There is usually some degree of ischemic neuritis distal to the fistula due to the vascular deficiency. The fistula itself presents a pulsating tremor with palpable thrill and increased local skin temperature. The portion of the extremity distal to the fistula is usually markedly swollen. Cardiovascular findings closely resemble those found in aortic regurgitation, beriberi heart and thyrotoxicosis. The

high pulse pressure, water-hammer pulse and other signs of reduced peripheral vascular resistance result in a chain of events such as develops from aortic regurgitation unless the abnormal circulatory dynamics is restored to normal. This may easily be done by surgical repair and closure of the arteriovenous fistula. Surgical treatment in some cases may re-establish good cardiac function even after disability of several years duration.

SUPPURATIVE PERICARDITIS

This is always a serious condition of the heart and pericardium. Its early recognition and treatment is frequently life-saving. Unfortunately the disease is often difficult to diagnose. If the patient does not succumb to the disease, it may become chronic and lead to invalidism. Suppurative pericarditis may result from a hematogenous borne infection or from direct extension from a pneumonia or empyema. The condition should be thought of in any serious febrile illness of doubtful etiology. When strongly suspected, exploratory aspiration of the pericardial space by needle is justified. As the condition is usually a manifestation of staphylococcus sepsis, pus may form rapidly in the pericardial sac. Since the pericardium does not have time to stretch, acute cardiac compression results, with decrease in cardiac output and signs of peripheral venous congestion.

The symptoms at first are those due to acute cardiac tamponade (such as are seen in contusion of the heart with hemopericardium) with signs of infection, and dyspnea from pulmonary compression. Later signs and symptoms of chronic cardiac compression may appear. The patient is usually acutely ill and extremely toxic from the pyogenic infection. Early in the course of the disease, friction rub may be present. When the purulent effusion is of considerable size, compression of adjacent lung tissue may result, with reduction of vital capacity to such a degree as to produce cyanosis. Usually there are electrocardiographic changes at some time in the course of the illness. The R-T segments are elevated in all leads or in leads I and II. There may be monophasic T deflections. These changes in the electrocardiogram are thought to be due to the associated subepicardial damage which always accompanies a purulent pericarditis.

After diagnosis is confirmed by aspiration of pus from the pericardial space, open surgical drainage is carried out. Pericardiocentesis is necessary at once if the vital capacity of the lungs falls below the critical level. Repeated blood transfusions and sulfanilamide drugs are frequently indicated. If the operation is successful, recovery is complete and permanent.

OBESITY AND THE HEART

Obesity is an important factor in producing a handicap to the respiration and circulation. The resulting inefficiency in the cardio-respiratory system manifests itself in the shortness of breath of stout individuals.

The factors concerned are the following: 1. There is a greater increase in the cardiac output during exercise in the obese than in those of normal weight. 2. The increase in the intra-abdominal fat affects the function of the diaphragm and the venous return of blood to the heart. The diaphragm is elevated, decreasing the vital capacity of the lungs by twenty to forty per cent. 3. Obesity impairs the functional capacity of the heart. Because of the high position of the diaphragm, the heart assumes a more horizontal direction, with rotation of the cardiac electrical axis and decrease in the mechanical efficiency.

Although obesity per se is usually not a direct cause of heart disease, obesity in patients with hypertension and arteriosclerotic heart disease is especially deleterious and a careful program of weight reduction is indicated. In these individuals, reduction in weight should be carried out even though heart failure is not evident. In many cases of so-called "middle-aged hearts" symptoms of heart disease perhaps might never develop were it not for the added load placed on the cardiovascular system by the over-weight condition—here weight reduction may actually act as a prophylactic measure to prevent or defer the onset of symptoms. Weight reduction in obese patients with organic heart disease should be accomplished gradually by a low caloric diet alone, as the administration of thyroid extract to individuals with coronary sclerosis may be a provocative measure in precipitating attacks of angina pectoris, coronary thrombosis and heart failure.

CHRONIC ANEMIA

Severe anemia of long standing may be a causative as well as a precipitating factor in producing heart disease. Interesting studies done in hookworm disease with its resulting anemia reveal that there is an increase in heart size in 100 per cent of cases of hookworm anemia. The cardiac enlargement may be due to dilatation or hypertrophy, and is entirely reversible if the anemia is corrected before the heart undergoes hypertrophy.

The effects of chronic anemia on the already diseased heart are of major clinical importance, as anemia is definitely an added drain on the cardiac reserve in valvular heart disease and hypertension. When the hemoglobin falls below fifty to sixty per cent of normal, the work of the heart is increased due to the increase in the per minute output from the heart. Also the myocardial anoxia in anemia greatly

lowers the cardiac reserve and leads to much earlier dilatation in these diseased hearts. The additional work speeds up the development of cardiac enlargement, may precipitate attacks of angina pectoris and cause premature congestive heart failure.

The treatment consists of abolishing the cause of the anemia, the hypochromic anemias responding best to iron and the macrocytic (pernicious) anemias to liver extract. A vitamin-rich diet should be used in addition to the specific treatment of the anemia.

TUMORS OF THE HEART

In recent years, greater efforts have been directed toward the ante mortem diagnosis of tumors of the heart. When these growths are not due to metastatic infiltration of the heart, they may be successfully removed by surgery. Although secondary tumors of the heart are being recognized with increasing frequency during the course of neoplastic disease elsewhere in the body, primary tumors of the heart still remain most difficult to diagnose. Changes in the contour or in the measurements of the heart borders when seen by careful fluoroscopy may give a valuable lead. Cardiac arrhythmias such as auricular fibrillation or ventricular premature contractions are oftentimes the only abnormal cardiac finding.

CONCLUSIONS

A number of disorders of the heart have been presented in which complete recovery of the patient under proper medical or surgical treatment usually occurs. It is important that we take a greater interest in the recognition of these curable forms of heart disease instead of continuing to interest ourselves mainly in the more common diseases of the heart from which complete recovery is rare.

The importance of the early recognition of this group of disorders is obvious. To effect a cure, treatment must be instituted promptly before irreversible changes in the heart occur.

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The average time required to cure forty patients with impetigo contagiosa, a contagious inflammatory skin disease, by local application of sulfathiazole (a derivative of sulfanilamide) in ointment form was nine and one-half days as compared with from twelve to sixteen days required with the previous conventional treatment, L. H. Winer, M.D., and E. A. Strakosch, M.D., Minneapolis, report in *The Journal of the American Medical Association* for January 17.

The two physicians explain that among the pus producing infections of the skin, impetigo contagiosa is the most superficial and also the most common.

CHRONIC NEPHRITIS AND HYPERTENSION— CLINICAL ASPECTS*

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When asked to present in this symposium the clinical aspects of chronic nephritis and hypertension, I was rather glad of the wide scope of the subject, as it would make any complete exposition impossible, and thus would permit a selection of some of the more interesting highlights of this subject about which so little has been known. Much active research work under the stimulating influence of Goldblatt's researches on hypertension is being carried on with perhaps the promise of further enlightenment and possibly of new therapeutic measures in the field of hypertension.

CLASSIFICATION

There are various classifications of the nephritic and hypertensive conditions, but the following arrangement is a simple and useful clinical classification into four groups; namely,

1. Acute nephritis.
2. Chronic nephritis
 - a. With edema
 - b. Without edema
3. Essential hypertension
 - a. Mild
 - b. Severe
4. Renal arterio-sclerosis

In the earlier course of the disease, the patient may usually be easily classified into one of these groups. However, later in the disease, it may be difficult or impossible to state whether the case began as an essential hypertension or as a chronic nephritis.

ETIOLOGY

The etiology of these different groups is partly known, partly unknown, but it is well to consider separately each of the three chronic groups; namely, chronic nephritis, essential hypertension, and renal arterio-sclerosis.

Chronic nephritis, with or without edema, may result from the following causes:

Firstly: as a sequella of an acute nephritis, and here three main groups of etiological factors predominate; namely,

1. The acute infections—especially those caused by hemolytic streptococci.
2. The ingestion of various toxic agents, notably bichloride of mercury, arsenic, and lead.

3. The toxemias of pregnancy.

In many cases, the development of a chronic nephritis from an acute nephritis can be conclusively demonstrated when the acute nephritis has been severe enough to bring the patient under the care of a physician. However, many cases of acute nephritis are so mild that the patient does not consult a physician, and is first seen only in the stage of a chronic nephritis, at which time there may or may not be enough evidence to trace the condition back to the original acute attack. The factors that may cause an acute nephritis to become chronic are unknown.

Secondly: chronic nephritis may occur as a sequella of a toxemia of pregnancy, either beginning acutely or with a chronic course from the onset. The etiologic factor in pregnancy producing either an acute or chronic nephritis is unknown.

Thirdly: chronic nephritis may occur as a complication of gout, and it is probably that the toxic effects of the uric acid are responsible for the nephritis as well as the other symptoms. When nephritis does occur in gout, it may be quite chronic, but it definitely prejudices the longevity of the gouty patient.

Fourthly: the development of a chronic nephritis as a complication of acute or chronic pyelocystitis is well known, although the great majority of cases of pyelocystitis clear up without developing this complication.

Fifthly: a chronic nephritis develops in the later course of all cases of essential hypertension. In the cases of essential hypertension there is always a period in which there is no evidence of nephritis, but sooner or later a nephritis develops. This may be only after many years in mild cases, or may occur rapidly in severe cases. The nephritis in these cases also varies greatly from a very mild type to a very severe type.

In renal arterio-sclerosis the urine shows a little albumin and a few casts. Renal function may be normal or slightly impaired. Depending upon the amount of renal damage, the signs and symptoms vary from practically none to those of a slight degree of chronic nephritis, and in the latter case it may not be possible to distinguish with certainty from other very mild types of chronic nephritis. The systolic blood pressure may be normal or slightly, or moderately elevated. In many of the cases, the diastolic pressure remains normal, and it is in these cases that the word "benign" may, if ever, be used in designating a hypertension. Clinically, renal arterio-sclerosis is seldom of importance.

Essential hypertension has long remained a very interesting and a very obscure condition. However,

* Presented at a meeting of the Sedgwick County Medical Society, October 7, 1941, as part of a symposium on nephritis and hypertension.

the pioneer work of Goldblatt published in 1932-'33 and '34 has aroused a great deal of interest. Goldblatt conclusively demonstrated that renal ischemia produced by constructing the arterial blood supply to the kidney, causes a continuous hypertension in experimental animals, apparently similar to essential hypertension in man, and probably due to a pressor vasoconstrictor substance elaborated by the affected kidney. In the last two years, Harrison on the one hand, and Page on the other hand, have independently produced anti-pressor kidney extract which when injected seemed to have a blood pressure reducing effect in the experimental hypertensive animal and in a few experimental clinical cases. This work, as yet, has not reached a stage of clinical application, but is at least the most promising lead that we have yet had in the management of essential hypertension.

PROGNOSIS

Given a case of chronic nephritis or essential hypertension, the estimation of the probable course and possible complications are important in prognosis and in the management of the case. There is no single criterion that may be used, but a number of factors placed together usually will give a fairly good insight into the expectations in any given case. The chief factors upon which judgment may be based are the following:

First: is the clinical history. This is always very important. A history of an acute nephritis followed by a rapidly progressing chronic nephritis gives a very bad prognosis. On the other hand, a clinical history of an essential hypertension with very slow progress gives a much better outlook and vice versa.

Second: is the condition of the cardiovascular system. Any evidence of blood vessel failure, especially if repeated, always indicates a more serious course. This evidence may be in the nature of repeated cerebral accidents, myocardial failure, coronary pain, or repeated retinal changes as determined by ophthalmoscopic examination.

Thirdly: are the urinary findings. The greater the amount of kidney damage as revealed by albumin, casts, red blood cells, or fixed low specific gravity, the poorer the prognosis and the more rapidly downhill the course may be.

Fourthly: the blood pressure findings determined a number of times over a course of one or two months or longer, give important prognostic indications. The height of the systolic pressure is important, but the height of the diastolic pressure is more so—and the higher the diastolic pressure rises above ninety mm. of mercury, the more danger there is, and a very high diastolic pressure of 120 to 140 is always a bad omen.

Fifthly: the blood urea test probably remains one of the most significant tests, and a nitrogen retention in either a chronic nephritis or an essential hypertension, as evidenced by an increased blood urea, always indicates approaching trouble for the patient, and increasing difficulty in the management of the case. The blood urea should be checked from time to time in all nephritic and hypertensive cases.

Sixthly: the phenolsulfophthalein functional kidney test is useful in conjunction with the other tests, but should not be relied on except in coordination with blood urea determinations.

By a study of these various factors; namely, the clinical history, the condition of the blood vessels and the heart, the urinary findings, the blood pressure readings, the blood urea test, and the phenol-sulfophthalein test, a fairly accurate estimate may be made in each case, which will serve as a guide to the prognosis and treatment.

MANAGEMENT

In the management of a case of essential hypertension, the following therapeutic considerations may be discussed:

(1) The general plan of the patient's living habits must be considered, and here individual variations in management must be made to suit individual conditions, circumstances, temperament, etc. The details must fit the individual case and most patients do better if comfortably occupied without being under undue physical, nervous, or mental strain. Restrictions in meat or protein intake are of no definite value unless there is an elevated blood urea, and then not of striking value. Excess weight, if present, should be reduced by a reduction in total calories. Reasonable reassurance to the individual, when possible, is desirable. Unwise restrictions of their occupation when the income is necessary to the existence of the patient and his family often do much more harm than good.

(2) The new anti-pressor substances discovered by Page and Harrison are still entirely experimental, and while of some promise, are as yet not available and not of proven clinical value.

(3) Surgery on the sympathetic system has been given a rather extensive trial during the past several years. I am convinced that it has little to offer and that it will soon fade out of the picture. Most of the cases that are chosen for the operation are mild cases that would have probably done very well without surgery, and in the more severe cases, it has failed to yield any definite results.

(4) The intelligent use of mild sedatives, chiefly phenobarbital or sodium bromide, are definitely of palliative value and should be used, preferably in very moderate dosage and preferably somewhat in-

termittently especially when using the bromides.

(5) This leaves for consideration in the management of essential hypertension one more drug that is proving to be undoubtedly the single best agent that we have so far found in the treatment of this condition; namely, potassium sulfocyanate or potassium thiocyanate. This drug has been used for some years, but the results were very variable and the dosage hard to regulate until the measurement of blood cyanate was developed. With this development, regulation of dosage has been much more satisfactory, and it is desirable to hold the blood cyanate between six and twelve mgm. percent, depending upon the individual response. The amount of drug necessary to maintain this level varies greatly in different patients from one to nine grains daily, with an average dosage of three to six grains daily. While the dosage is being regulated, the blood cyanate level should be determined every one or two weeks, and after the dosage level has been regulated, the blood cyanate level should be checked every one or two months. Where the response is satisfactory, the patient is kept on this medication indefinitely. Some patients do not tolerate the drug well, and it will have to be discontinued in these cases. The undesirable toxic effects that occur occasionally are toxic skin rashes, cerebral confusion, weakness, and an occasional death has been reported. The desirable therapeutic effects, which are rather frequently but not always obtained, are a considerable lowering of blood pressure, both systolic and diastolic, with improvement of the myocardium due to the lessening of strain, a lessening of the feeling of nerve tension, and improvement in the general well-being of the patient. It is difficult to say at what point thiocyanate should be begun in a case of hypertension, but in the average case of persistent blood pressure readings of 180, systolic and 100, diastolic or higher, it is well to consider the use of this drug. While it does not cure the condition, it is undoubtedly the best drug so far found for these patients. The more evidence there is of kidney damage, the lower the dosage necessary, because it is more slowly eliminated. The blood cyanate determination is a simple test and the drug should not be used without regular checking of the blood cyanate level. The patient must keep under repeated observation, and it must be held in mind that there are some dangers connected with the use of this medication.

In occasional instances in essential hypertension, the patient may be found to have a unilateral atrophic pyelonephritic kidney, and in some of these cases the removal of the unilaterally ischemic diseased kidney has cured the hypertension. This fits in with Goldblatt's experimental work, and this

possibility should be held in mind in studying hypertensive cases as an occasional apparently brilliant curative result may be obtained by the surgical removal of a unilaterally diseased kidney.

In the treatment of chronic nephritis, we must confess to ourselves our utter helplessness in altering the progress of the disease. However, even so, we must never lose sight of the fact that patients with hopeless conditions need the care of a physician, and it is our duty to lend them hope, keep up their courage, give advice, give medication—even if it has only psychologic and not physical benefit. These things the wise physician will do even in these cases where we realize we cannot cure the condition or essentially alter its course.

The use of thiocyanate for control of the blood pressure should be tried in chronic nephritis, but the greater the kidney damage the lower the dose required to keep up the cyanate level.

The edema when present may be a very trying complication. If there is no nitrogen retention, as evidenced by a normal blood urea, give a high-protein diet, blood or plasma transfusions, low salt intake, moderate fluid restrictions, ammonium chloride or potassium nitrate—four to eight grams daily, and if no result with these, add to them the use of salyrgan theophyllin, either intravenously or intramuscularly. If the edema is associated with a nitrogen retention, as evidenced by a high blood urea, the use of a high protein diet and of the transfusions must be more cautious, as it may increase the nitrogen retention, and in this situation, its use must be regulated by the individual response of each patient.

The last part of the subject that I wish to consider is uremia, and here two types of uremia must be differentiated; namely, an acute convulsive uremia, probably due to a disturbance in fluid and electrolyte balance especially in the central nervous system cells, and may occur with a normal blood urea. This type of uremia may occur in acute nephritis, chronic nephritis, and in the toxemia of pregnancy, and the management is the treatment of the underlying disease cause, plus salt restriction, fluid restriction, sedation with morphine or chloral hydrate, spinal puncture, and the use of magnesium sulphate intravenously or intramuscularly.

True uremia is due to the retention of urea and occurs in acute nephritis, chronic nephritis, and certain extra renal conditions such as severe alkalosis. In a chronic nephritis, not much can be done for a true uremia. Protein intake should be restricted, but the development of a true uremia in a chronic nephritis indicates that the course of the disease is nearing a fatal termination. In acute nephritis, a

(Continued on Page 23)

President's Page

To the Members of The Kansas Medical Society:

It is apparent that the rapidly expanding Army and Navy will necessarily continue the ever increasing demand for medical officers for the armed forces.

Let us individually ask ourselves the question where can I best serve my country in its efforts to win the war, that in the end freedom and peace may again be established throughout the world. It is apparent great sacrifices must be made by the profession. As a whole, may we accept freely the responsibility imposed upon us by responding to our Nation's call through the procurement agencies set up by the government. The greatest service we can render as physicians is in no way commensurate with those of the fighting personnel at the front.

It is regretted that at the moment no facts and figures are available other than the statement of need. It is hoped that in the near future more detailed information as to requirement numbers and classification data may be made available for publication.

Enough to say we are at war. Our country calls—we must respond.

Sincerely yours,

Clyde D. Blake M.D.

EDITORIAL

THE NEW COVER

The Journal has considered during the past several years the possibility of adopting a new cover format. The change was being contemplated with the thought of providing certain facilities for advertisers who desire to use more than one color in their advertising and with the further thought that occasional revision of format tends to provide advantages of progress and reader interest.

The cover, which appears on this issue, represents the decision which has been made in this regard. The Editorial Board hopes that the change will meet with the approval of the membership.

CANCER FACTS

Cancer in Physicians: One out of each ten deaths among physicians for the last five years has been from cancer. An editorial in a recent Journal of the American Medical Association suggests that doctors practice what they preach and have a periodic physical examination for the early detection of cancerous conditions. Certainly, the question of expense cannot be an item of delay or failure to indulge. Is it because doctors are such notorious fatalists? Is it just neglect? Is it just indifference? Surely doctors must be in agreement upon the ability of periodic examinations to detect early symptoms of cancer and upon the values of early treatment. Some county societies are small enough to organize periodic examinations as one of their monthly programs each year. Laboratory facilities and roentgen examinations would be available without argument as to costs.

Cancer Among Physicians Wives: The percentage of cancer deaths of uterus and breast among doctor's wives is going to be higher than the cancer mortality of their husbands. How many physicians suggest or complete periodic examinations in their families? What is the use of knowing so much if there is failure to use that knowledge and profit by experience? What about periodic examinations of the membership lists of the Women's Auxiliary? This might be extended to the laity by those regimented in the Women's Field Army. Surely, physicians would be agreeable to conducting such an experimental periodic physical examination campaign with little expense.

Alvarez has criticised the neglect of physicians in

regard to gastro-intestinal ulcer and cancer and McFarland has shown the high values of voluntary periodic examinations in large groups of women at Philadelphia. We all know the values of early diagnosis and prompt treatment. That is why we support cancer conferences. Isn't it about time that we profited by our own advice? Or are we just shoe-maker's children? Can we do something about it? We could.—Edward H. Skinner, M.D., Kansas City, Missouri.

SOME SLIGHT SILVER LINING

Practically every doctor, no matter how old or young, is committed to certain financial obligations which make it doubly difficult for him to go into military service. Not the least of these obligations are taxes, insurance, mortgages and rents. In order to alleviate somewhat this strain from one who joins the armed services, Congress, in 1940, passed the "Soldiers and Sailors Civil Relief Act" ". . . to promote and strengthen the national defense by suspending enforcement of certain civil liabilities of certain persons serving in the Military and Naval establishments."

In regard to insurance, the act states:

Sec. 405. No policy which has not lapsed for the nonpayment of premium before the commencement of the period of military service of the insured, and which has been brought within the benefits of this article, shall lapse or be forfeited for the nonpayment of premium during the period of such service or during one year after the expiration of such period: Provided, That in no case shall this prohibition extend for more than one year after the date when this Act ceases to be in force.

The provision concerning property taxes reads:

Sec. 500. (1) The provisions of this section shall apply when any taxes or assessments, whether general or special, falling due during the period of military service in respect of real property owned and occupied for dwelling, agricultural, or business purposes by a person in military service or his dependents at the commencement of his period of military service and still so occupied by his dependents or employees are not paid.

It continues in regard to income taxes as follows:

Sec. 513. The collection from any person in the military service of any tax on the income of such person, whether falling due prior to or during his period of military service, shall be deferred for a period extending not more than six months after the termination of his period of military

service if such person's ability to pay such tax is materially impaired by reason of such service. No interest on any amount of tax, collection of which is deferred for any period under this section, and no penalty for nonpayment of such amount during such period, shall accrue for such period of deferment by reason of such nonpayment.

We suggest that any doctor going into service write his Congressman or Senator for a copy of the Act under the title "Public No. 861, 76th Congress, Chapter 888—3rd Session S 4270."—The Journal of the Indiana State Medical Association, January, 1942.

WORKMENS COMPENSATION

WORKMEN'S COMPENSATION —WHAT IT IS AND WHAT IT IS NOT

Mr. Erskine Wyman*

Topeka, Kansas

1. Q. Upon what theory was the idea of Workmen's Compensation founded?

A. The law is founded upon the principle of insurance, and is in no sense a pension, or bounty or gratuity.

2. Q. When and where was the idea put into practice by law?

A. Germany in 1884. England in 1897. All countries in Europe, the provinces of Canada and Australia ten years prior to any attempt in the United States. Ten of the United States enacted laws in 1903; now all states except Mississippi have workmen's compensation laws.

3. Q. Who has been responsible for the enactment of workmen's compensation legislation?

A. The employer and employee. Employers were subject to losing large amounts in money and time defending suits for damages. Amounts paid out in damages and attorneys' fees were enormous; sometimes causing bankruptcy of employers. Employees and their families were left destitute. Recovery was had in only about thirty per cent of damage suits filed. Payment of compensation may be looked upon the same as repair or replacement of industrial equipment.

4. Q. Who pays the cost of workmen's compensation?

A. The consumer pays the cost in the purchase price of goods.

5. Q. What are the maximum amounts which may be recovered under workman's compensation laws?

A. Under the Kansas workmen's compensation law only a dependent may recover for death of a workman incurred in the course of employment. The amount to be recovered depends upon the average annual earnings of the workman, and \$4,000.00 is the maximum which may be recovered; in addition, \$150.00 for funeral expenses, and not more than \$500.00 to cover medical and hospital expenses. For bodily injuries under the Kansas compensation law the maximum which can be recovered is not more than \$18.00 a week, payable for not to exceed 415 weeks. In addition, the law provides for scheduled amounts for injuries to bodily members.

6. Q. Does the workmen's compensation law apply to occupational diseases?

A. Not in Kansas. In many states it does.

7. Q. What employments are covered in Kansas?

A. All employments in which five or more employees are employed in a hazardous occupation. In building and mining work where one or more are employed.

8. Q. Can employers elect to operate under the law?

A. They can. About 1,000 a year do.

9. Q. How must the employer make the payment of compensation secure to the injured employee?

A. The employer must either take out an insurance policy with some company qualified to write such insurance, or prove himself financially able to carry his own insurance by qualification with the workmen's compensation commissioner.

10. What is the penalty for not qualifying to secure the payment of compensation?

A. There is no criminal penalty. The employer might be subject to a suit for damages and a large recovery had against him.

11. Q. When is compensation payable?

A. No compensation is paid for the first seven days of disability. After that compensation is payable at the same time as wages were paid.

12. Q. What is the rate of compensation payments?

A. Compensation is payable at the rate of sixty per cent of the average weekly wage, with a maximum of \$18.00 per week and a minimum of \$6.00 per week.

13. Q. For how long and for how much is compensation payable?

A. For permanent total disability, 415 weeks at

*Workmen's Compensation Commissioner, State of Kansas.

the weekly compensation rate. For permanent partial disability, 415 weeks at the percentage of permanent partial disability, depending upon the rating in percentage of disability determined. The law provides the compensation payable for loss of fingers, hand, arm, toes, foot, leg, eyes, or ears. For loss of the use of these members compensation is payable based upon the percentage of loss to use such members in the performance of labor.

14. Q. Who determines the percentage of partial general disability or the percentage of loss of use of scheduled members?

A. The Workmen's Compensation Commissioner.

15. Q. How does the Commissioner determine and rate the percentage of disability?

A. In almost 100 per cent of the cases the Commissioner must depend upon the percentage rating given by physicians who in some manner have become familiar with the particular case.

16. Q. How much does the law allow for medical and hospital treatment?

A. The employer must furnish medical and hospital treatment, but he is only liable for such medical and hospital treatment in the amount of \$100.00, and when it is found to be an extreme case, in the amount not to exceed \$500.00.

17. Q. When the maximum amount provided by law — \$500.00 — has been reached, who must the physician or hospital look to for their bill?

A. They must look to the patient as in a private case.

18. Q. In case the maximum amount for medical and hospital attention is exceeded by the employer, how is the money due in compensation for such attention divided?

A. The amount of \$500.00 is prorated in accordance with the amounts due the various parties.

19. Q. Who chooses the physician?

A. The employer chooses the physician.

20. Q. Must an employee undergo examination by a physician?

A. Yes. The injured employee is required to submit to examination upon request of the employer and at the expense of the employer. Refusal to submit to examination forfeits compensation payments.

21. Q. Can the employee choose a physician?

A. Yes, but he must pay the physician himself.

22. Q. Can the employee change from a physician furnished by the employer to one of his own choosing?

A. Yes, but he must pay the physician himself, unless the employer voluntarily agrees to the change, or on application and showing at a hearing before the Commissioner a change in physicians is ordered.

23. Q. How are compensation claims determined?

A. 1. By agreement. 2. By hearing held before the Commissioner.

24. Q. How many cases are settled by agreement and how many by hearing before the Commissioner?

A. About ninety-five per cent of the cases are settled by agreement and the remainder by hearing before the Commissioner. In 1940 about 4,000 cases were determined by agreement, and about 700 by agreed award and upon determination by the Commissioner.

25. Q. How are cases determined by agreement?

A. The Commissioner has established a form which must be used for the purpose of setting out the disability rating and the compensation paid. This form of agreement must be accompanied by a physician's report on a form established by the Commissioner, showing the nature and extent of the disability and rating of disability as established by the physician making the report. The agreement must comply with the law as to number of weeks of compensation due and the rating of disability as established by the physician whose report accompanies the agreement.

26. Q. How are cases determined when no agreement can be reached and it is necessary to have a hearing before the Commissioner?

A. The case is heard by the Commissioner and the testimony of the witness is transcribed and made a permanent record. The percentage of disability is determined by the opinion of physicians testifying in the case.

27. Q. Can the Commissioner appoint a neutral physician to make an examination of the claimant and testify as to his findings?

A. Upon the request of either party, the Commissioner can appoint a neutral physician and assess the costs to either party.

28. Q. What financial benefits does the physician receive from the operation of the workmen's compensation law?

A. Statistics show that of the costs paid out by reason of the operation of the workmen's compensation law, \$1.00 out of every \$3.00 goes to the physician.

29. Q. Is there any formula or guide through which a physician can be taught how to determine or which he can follow in order to determine the rating of the percentage of disability, either as to percentage of general disability, or percentage of loss of use or disability of a scheduled member?

A. There is no formula or guide. This question constitutes the main difficulty to the Commissioner in the administration of the law, and to the physician whose practice includes industrial work. The ratings are founded upon opinion. An opinion may be

defined as a guess dressed up in evening clothes. The physician attempting a rating should do so only after careful thought from the standpoint of the injured party, and ease of his own conscience. There are several textbooks on the subject. Kessler and Fraser have been found useful and helpful.

As a basis for the commencement of his studies on how to make disability ratings, a physician should read and familiarize himself with Section 44-510 of the Kansas workmen's compensation law. A copy of the law will be furnished any physician desiring the same upon request being made of the Kansas Workmen's Compensation Commissioner, 801 Harrison, Topeka, Kansas. Any lawyer acquaintance would no doubt be willing to allow a physician to read the section out of his statute. A reading of this section will give the physician an idea of what is to be accomplished by the cooperation of the physician and the Commissioner.

The physician after reading the above section will note that there is a distinction between the terms "loss of" and "loss of use of." With reference to scheduled disability, compensation can be calculated easily as to the "loss of" the member. Where there is a loss of a member, the important thing to determine and impart for the information of the Commissioner is to point out specifically the place where the loss of the member occurred as this makes a difference in calculation. For example: The loss of the distal phalanx in the distal joint of the index finger would require by law compensation for one-half the loss of the finger as set forth in the compensation law. However, loss of any part of the bone, regardless of how small, from the distal point of the middle phalanx, would require by law that compensation be calculated as loss of two-thirds of the index finger, and loss of any part of the bone, regardless of how small, from the distal point of the proximal phalanx of the index finger, would require that compensation be calculated on the basis of loss of the entire finger. Some physicians feel that this is unfair for the reason that it is sometimes necessary to remove a small part of the bone of a joint in order to form a pad. The physician should not allow this fact to enter his thoughts whatsoever in performing the best service possible. Insurance rates are established to take care of such situations, and the physician should not allow facts which do not concern him to enter into the services he is called upon to perform. In considering loss of a member, the law provides that removal of any part of the member below the elbow constitutes loss of a hand. In making amputations in the elbow, removal of any part of the bone of the upper arm constitutes, as a matter of law, loss of the arm, and

the same remarks would be applicable as were mentioned about the index finger.

In making a rating of disability as to the "loss of use of" a member, or a general disability, such as a back injury, these points should be borne in mind. The rating is to be made on the percentage of ability to use the member in the performance of labor, or, in the case of general disability, the percentage of ability to perform labor. In considering what the performance of labor is, the rating is not to be confined to the particular job which was being performed at the time the accident happened, but it must also be considered that, as a laborer, the patient might be called upon to do any kind of manual labor. Consider the fact that the patient might be called upon to be an oil field worker, a ditch digger, a packing house worker, or a skilled laborer. Fuse all these thoughts in mind and you have what the performance of labor is. In considering the percentage rating of disability, consider that the percentage is to be some place between 0, when the member cannot be used at all, or, in a general disability, when the patient can perform no function at all, and the figure 100 per cent when the patient can do all things demanded of a laborer. As to a scheduled member, take for example again the index finger. Assume that all the pathology of the difficulty is located in the distal joint. The percentage of rating is not to be applied as to the distal joint alone, but the percentage rating is to be based on the loss of the use of the entire finger to perform labor. The resultant percentage of the physician's opinion might be the same, but the opinion is to be based on the loss of the use of the whole finger to perform labor. The physician should then determine all the pathology involved in the finger, and the ability of the injured party to use the finger in the performance of labor. When this has been done he should formulate his percentage at somewhere between 0 and 100 and as stated before, this can only be done through the physician's opinion based upon his general knowledge of the work of a laborer, and the pathology he finds in the injured member. In considering such percentage, the evaluation of the percentage of disability to the finger is not to be considered in conjunction with the loss of use the injured party will have to his hand, by reason of the loss of the use of the finger. The hand and the finger constitute separate scheduled members under the law, and are to be considered separately. For instance, assume an oil field worker lost his hand or had loss of use of the hand. The fact that because of the injured party losing his hand he is now unable to do oil field work at all, doesn't mean that he should be rated as totally disabled because he can-

not now use his hand, or that no one will hire him to do oil field work because he has lost a hand. The law provides, and our Supreme Court has held, that such loss or similar losses are specific scheduled injuries under the law, and must be accounted for as such. In rating a loss of use of the arm below the elbow, which constitutes a hand according to the schedule provided in the law, the rating must be placed at that percentage of disability to perform labor as to the hand only, and be placed at somewhere between 0 and 100.

Rating a general disability is more difficult yet. An example of a general disability may be made as to a back injury, because such injury occurs most frequently. The question arises that even though a laborer is unable to do any lifting or straining whatsoever on account of his back, should credit in percentage be given to the fact that there is no loss of the use of his legs, his arms, his eyes, or his ears? In establishing the percentage some place between 0 and 100, should some credit be given to the fact that the injured party can walk, tie his tie, eat, see, and hear as well as anyone? As to whether or not such credit should be given depends in the opinion of this Commissioner upon the particular facts involved. Take for example a miner who has done nothing but mine coal all his life. He has no education. He injures his back. Although he has the use of all of his members, there is no occupation he can perform. In some instances awards have been made for total disability where the injured party has no disability whatsoever except when he goes to lift or strain. Again the facts would have to determine as to how much credit should be given in percentage, because there is no disability at all except when lifting or straining is involved.

The Commissioner can only call these matters to the attention of the industrial physician in order that they may be useful to him in formulating his opinion as to percentage of disability. Where a physician is testifying at a trial he should be independent as to his opinion. He should not follow the opinion of another physician he has heard testify, but should give his own independent judgment and stick with it. If attorneys argue with him as to his opinion, he can always answer by saying that the estimate is an opinion of his on a question on which he has been called to give his best guess, and, having done so, it can be taken for what it is worth by the attorneys or by the Court. Physicians should not allow their emotions to get the best of them or show while they are testifying. It is, of course, sometimes necessary to explain, but most of the time short direct answers simplify the determination of the question, shorten the length of time it takes to give testimony, and

answers argumentative examination. A physician should not refuse to give an opinion as to percentage of disability either when he is testifying in a case or upon a medical report which is to be submitted to the Commissioner for determination of disability on a settlement agreement. The law demands that the Commissioner must make a decision. The Commissioner should have the cooperation of the physician by receiving the benefit of trained medical opinion. The physician should be willing to stick his neck out along with the Commissioner, because, after all, industrial problems raise questions which must be disposed of in an orderly way, and the fact that a physician might be subject to cross-examination by attorneys skilled and unskilled should not deter his position in accepting responsibility toward the administration of the workmen's compensation law. In closing it might be helpful, while testifying, to remember some philosophy that has stood the test for five thousand years. It is found in Chapter Fifteen of Proverbs, paragraph one: "A soft answer turneth away wrath; but grievous words stir up anger."

MEDICAL SCHOOL

CLINICAL PATHOLOGICAL CONFERENCE OF THE UNIVERSITY OF KANSAS HOSPITALS*

CASE I

Diagnosis: A case of atypical regional ileitis with portal and mesenteric thrombosis.

Dr. Wahl: "Dr. Douglas will you present the clinical history of this case?"

Dr. H. L. Douglas: "E. H. A white male, aged seventy-six entered the University of Kansas Hospitals, July 24, 1940, with spells of vertigo, nausea, and vomiting. A diagnosis of diabetes mellitus, generalized arteriosclerosis, and a diabetic cataract was made and he was dismissed on a diabetic regime.

He was readmitted to the hospital September 28, 1941, complaining of diarrhea of three months duration. The stools were watery but without trace of blood. He was quite nervous and at times mildly psychotic.

The physical examination revealed an emaciated,

*The Clinical Pathological Conference of the University of Kansas Hospitals is held weekly, under the supervision of Dr. H. R. Wahl, Professor of Pathology; and is regularly attended by the senior medical students, hospital staff and faculty.

aged male unable to move without assistance. There was a cataract of the right eye. The mouth was edentulous. The blood pressure was 125/80. The heart was displaced upward and laterally. There were rales in both bases of the lungs. There was shifting dullness and distention of the abdomen. The peripheral vessels were quite sclerotic.

Laboratory examination revealed a red cell count of 4,210,000, a white cell count of 11,700, a hemoglobin eighty per cent, and the differential count showed eighty-five per cent polymorphonuclear leukocytes. The serology was negative. Blood chemistry was essentially negative except for a fasting blood sugar of 127 mg. Stool examination was negative for parasites but persistently positive for blood.

He was treated symptomatically until his death which occurred eight days after admission."

Dr. Wahl: "Dr. Douglas, what did you consider the cause of this patient's rather sudden death?"

Dr. Douglas: "We thought it was due to arteriosclerotic heart disease."

Dr. Wahl: "Did the patient have any elevation of temperature?"

Dr. Douglas: "His temperature on admission was 98.8 degree and the highest recorded was 99.6 degrees on the third hospital day, after which his temperature was normal."

Student: "Was there any abdominal tenderness?"

Dr. Douglas: "There was no abdominal tenderness."

Dr. Wahl: "Dr. Bowser will you demonstrate the x-ray plates of this patient?"

Dr. John Bowser: "Flat plates taken a year ago July 4, 1940, show nothing unusual in either the stomach or colon, except for increased irritability of the descending colon. A gall bladder visualization, at that time, we considered normal. We did not see the patient again until (September 30, 1941) when the colon showed more marked irritability than before. At this time there was also narrowing of the ileocaecal valve. The stomach showed a defect at the cardia which we thought might be due to organic pathology but later examination revealed that the cardia had filled out to normal contour."

Dr. Wahl: "Do you think the irritability of the colon was due to ulceration?"

Dr. Bowser: "No, we did not think so."

Dr. Wahl: "Was an E.K.G. made on this patient?"

Dr. Douglas: "No."

Dr. Mahlon Delp: "Dr. Bowser, was there any slowing of the progress of the barium through the small intestine?"

Dr. Bowser: "Yes there was slowing, but we did not consider it significant at that time."

Dr. Delp: "Do you consider it significant now?"

Dr. Bowser: "Possibly. As you can see from the plate the barium which should be in the colon is still in the small intestine. Eighteen months ago there was thirty per cent retention in the stomach after three hours."

Dr. Wahl: "Dr. Mills, will you give us the post mortem findings?"

Dr. Fred Mills: "The thoracic cavity contained 1000 cc. of fluid on the left and fifty cc. on the right.

The heart was not enlarged, the coronary arteries showed considerable atherosclerosis. The heart was moderately dilated.

The lungs showed emphysema, congestion and oedema and possibly some early bronchopneumonia.

The liver showed wrinkling of the capsule and was smaller than normal.

Several healed infarcts were found in the spleen and there was adhesive perisplenitis.

The ileum at a point one meter above the ileocaecal valve and for a distance of fifteen cms. showed externally a thick purulent exudate on the serosa and the omentum was loosely adherent at this area. The wall of the gut at this point was thickened, hemorrhagic, ulcerated, and gangrenous. The veins draining this segment were found to contain thrombi in the lumina, and many of the radicals of the portal system of veins also contained extensive thrombotic masses some of which could be traced into the hilum of the liver. These were firmly adherent to the wall of the vessels at many points."

Dr. Wahl: "Dr. Walker, will you give the microscopic findings?"

Dr. G. A. Walker: "Sections through the heart and coronary arteries showed atherosclerosis with chronic fibrous myocarditis. There was early bronchopneumonia with congestion and oedema of the left lung.

The liver showed parenchymatous degeneration and there were thrombi with numerous polymorphonuclear leukocytes in many of the intrahepatic veins.

The spleen showed healed infarcts and areas of recent necrosis. The pancreas, in spite of the clinical diagnosis of diabetes showed relatively little. There was some interacinar fibrosis and a few islands appeared hyperplastic. Some of the pancreatic veins contained thrombi and there was a considerable area of recent necrosis in one section with acute inflammatory reaction at its margins.

Sections through the small intestine in the area of gross gangrene showed a thickened fibrotic serosa infiltrated with mononuclear leukocytes which extended into the muscular layer, the submucosa contained abundant hyaline fibrin showing beginning organization, the epithelium of the mucosa was miss-

ing and in part replaced by a layer of hyaline fibrin with moderate mononuclear infiltration. The mesentery showed extensive hemorrhagic infiltration of the fatty tissue with deposits of fibrin and beginning organization as well as round cell infiltration.

Sections through various radicals of the portal vein showed thrombi in the lumen with organization of such degree as to indicate a duration of not less than three or more than six weeks. The lesions in the small intestine were fairly typical of those seen in regional ileitis, except for the unusually extensive thrombosis.

Dr. Wahl: "The most interesting finding in this case is the presence of an area of localized chronic inflammation in the segment of small intestine, associated with hemorrhagic infiltration of the mesentery and thrombosis of the veins in this area. The organization indicates that the process is four to six weeks old. There was a propagated thrombus extending from the area of inflamed small intestine along the radicals of the portal system all the way to the hilum of the liver and into the liver itself."

As Dr. Walker suggested, this is an example of regional ileitis with portal thrombosis and obstruction. It is probably that this patient had some other pathological process underlying the one in the small intestine. There is extensive atherosclerosis involving particularly the coronary arteries and many of the arteries in the splanchnic area, the splenic artery is particularly tortuous and sclerotic, there are old and recent infarcts in the spleen, and a recent infarct in the pancreas. It is possible that this patient had a vascular occlusion as a result of atherosclerosis in the mesenteric vessels leading to infarction of a part of the small intestine with subsequent infection and secondary thrombosis of the veins, ultimately extending along the portal system into the liver. There may also have been a terminal spasm of the coronary artery at some point, thus accounting for the patient's rather sudden death. There was undoubtedly considerable toxemia from the intestinal infection as well as the early broncho pneumonia and this also played a part in the fatal result. This patient was nearly eighty years of age and this advanced age may account for the fact that there were few clinical signs or symptoms referable to the intestinal condition, diarrhea being the chief indication of disturbed function in that organ."

Dr. T. G. Orr: "I wonder if this is a true case of regional ileitis. I do not think that this patient had the clinical picture or the age to fit a diagnosis of regional ileitis. Do you not think that this was a case of thrombosis of a mesenteric artery?"

Dr. Wahl: "From a purely morphological viewpoint, this was a case of regional, that is to say, local-

ized inflammation of the ileum, but as I stated it was likely secondary to a vascular occlusion as a result of atherosclerosis in the mesenteric vessels, and therefore not a true example of the clinical syndrome called regional ileitis."

Dr. Delp: "I believe with Dr. Orr that this is hardly a true picture of regional ileitis, which is a disease of young people often mistaken for appendicitis. X-ray pictures in true regional ileitis usually show a dilated gut, but in this case there was no such finding in the x-ray."

Question: (Student) "How do you account for the fact that this patient had such an abdominal lesion without tenderness or rigidity of the abdomen?"

Dr. Hashinger: "We are discussing a patient whose age was nearly eighty. All symptoms are minimized in a person of that age. Death may occur from acute peritonitis and yet the patient has a soft abdomen and little tenderness."

CASE II

Diagnosis: Bilateral tumors of the adrenal glands.

Dr. Wahl: "Dr. Douglas will you give us the history in the next case?"

Dr. H. L. Douglas: "H. C. A white male thirty-eight years of age was admitted to the University of Kansas Hospitals, October 2, 1941, complaining of cough, pain in the abdomen and chest. The onset of illness was rather indefinite as the patient stated that he had had a cough ever since he could remember. Seven months ago he developed weakness and pain in the chest, both of which have been progressive. The past medical history and family history were negative."

The physical examination showed an emaciated, middle aged, white male, who appeared acutely ill. Conjunctiva were quite pale. The nose had a saddle shape with no perforation of the septum. The teeth were in poor condition, the uvula was absent and there was a small perforation of the soft palate in the middle line. A hard nodule could be felt beneath the right sternocleidomastoid near the angle of the jaw. This nodule measured about three cm. in diameter and was freely movable. The blood pressure was 120/76. There was increased dullness in both apexes and crackling and mucoid rales in both bases. Tubular breathing was present over the left apex. There was marked clubbing of the fingers.

Laboratory examination revealed a red blood count of 3,670,000, a white cell count of 15,800, and a hemoglobin of sixty-eight per cent. Urine analysis was persistently negative except for a faint trace of albumin. The serology was negative and the blood chemistry showed nothing abnormal."

Dr. Wahl: "What was the clinical diagnosis?"

Dr. Douglas: "From the history and particularly the x-ray findings we thought this patient had a hypernephroma of the kidney."

Dr. Wahl: "Dr. Tice, will you discuss the x-ray findings?"

Dr. Galen Tice: "The chest plate showed a large opacity in the upper left lung field and numerous smaller shadows throughout both lungs. There was infiltration in the right lung apex which, from an x-ray standpoint we would call tuberculous. The right kidney was displaced downward and the duodenum was displaced toward the midline, findings which were interpreted as indicating the presence of a tumor mass at the upper pole of the right kidney. Also there was an indistinct mass in the small intestine causing an indentation in the shadow of the nearby duodenum. Our conclusion was that there was probably a tumor in the right adrenal gland."

Dr. Wahl: "Dr. Dietrich, will you state the post mortem findings?"

Dr. Alfred Dietrich: "The body showed marked emaciation. There was a tumor mass at the angle of the jaw on the right and a small nodule above the clavicle on the left. There was a large tumor mass in the apex of the left lung and numerous smaller masses throughout both lungs near the periphery. There were numerous pleural adhesions. A mass of tumor tissue was seen in the right leaf of the diaphragm, several fairly large tumor masses were present in the wall of the small intestine and the largest tumor masses were found in the region of the adrenal glands on both sides. All these masses of tumor tissue were yellow in color and rather friable as well as necrotic in some parts. The tumor did not invade either kidney, the adrenal masses weighed 110 grams and 130 grams respectively.

The right lung apex showed diffuse induration with a few bronchiectatic cavities, some of which contained purulent material.

The heart was acutely dilated."

Dr. Wahl: "Dr. Walker, will you discuss the pathological findings?"

Dr. G. A. Walker: "The pathologist has two questions to answer in this case.

What is the nature of the tumor?

Why did the patient die?

To answer the last question first there are three possible mechanisms of death as a result of malignancy. The first is secondary infection with sepsis or hemorrhage at the site of the primary tumor or some of its metastases. A second is obstruction of some vital passageway, or pressure upon some vital organ. Neither of these mechanisms can be blamed for the patient's death in this case, the third mechanism is cachexia and by exclusion must be considered

the effective process here, although the presence of a purulent bronchitis with bronchiectasis must have played a minor role also.

The infiltration in the right lung apex proved to be diffuse fibrosis with bronchiectasis and purulent bronchitis, no evidence of tuberculosis could be found.

The tumor nodules in the various organs all showed essentially the same histological picture, consisting of giant cells with abundant cytoplasm sometimes showing vacuolization but more commonly the cytoplasm was finely granular and eosinophilic. The nuclei showed marked variation in size, shape, and staining reaction with irregular lobulation and marked hyperchromatism in many instances, mitotic figures were frequently seen, often bizarre forms were present and there were many areas of necrosis and hemorrhage with more or less inflammatory infiltration. These cells were closely packed, being separated from each other by a delicate reticulum of connective tissue, there was no tendency to form acini or alveoli. Fat stains showed that there was only a moderate amount of lipoid material present, nothing like the picture that one sees in a hypernephroma. The tumor nodules in the wall of the small intestine had obviously been metastatic in origin, growing from the serosal side and invading the muscle layer and later the mucosa which sometimes showed ulceration. In the lung the tumor cells could often be seen extending into and filling up many of the alveoli producing a typical picture of neoplastic pneumonia, in some fields the alveolar epithelium was displaced or replaced by tumor cells. A striking feature in the lung was the presence of numerous very large phagocytic cells, sometimes containing as many as fifty ingested polymorphonuclear leucocytes. These phagocytes occasionally showed hyperchromatism of the nuclei and irregular lobulation suggesting that they were actually neoplastic cells. The identity of this tumor is a matter of some uncertainty. In spite of the yellow color in the gross and the fact that there were nodules in the small intestine the possibility that this tumor was a malignant carcinoid or argentaffin tumor primary in the small intestine can be definitely ruled out on the basis of the cytology alone. There remains the possibility that it is a bilateral adrenal cortical carcinoma, or a bilateral malignant paraganglioma of the adrenal glands. The relative paucity of lipoid material tends to rule out a cortical origin, although there are in the literature reports of giant cell malignancies derived from cortical epithelium in which little lipoid or glycogen can be demonstrated, unfortunately special staining methods applied to the material in this case do not definitely settle the ques-

tion as to the origin of the neoplastic cells, silver stains show only a fine granular impregnation with chrome salts, however the cells are so poorly differentiated that such a failure to react in a typical manner does not at all rule out a diagnosis of paraganglioma.

Our final conclusion is that this tumor is a bilaterally primary malignancy of the adrenal glands arising in the medullary epithelium, a malignant paraganglioma with metastases to the lungs, kidneys, pancreas, diaphragm, small intestine, mesenteric and supraclavicular lymph nodes.

The bronchiectasis and bronchitis probably had no direct relation to the neoplastic process."

Dr. Orr: "Does this type of tumor affect blood pressure?"

Dr. Walker: "Tumors of this type are commonly associated with paroxysmal hypertension. There are, however, numerous reports of tumors of the adrenal glands, in both the cortex and medulla but without any clinical manifestation of adrenal dysfunction."

Dr. Tom Hamilton: "Is the diagnosis of malignant carcinoid entirely ruled out?"

Dr. Walker: "Yes, the cytology is definitely not that of a carcinoid."

Dr. Orr: "Is there any way of making the diagnosis of paraganglioma clinically?"

Dr. Walker: "The cytological diagnosis cannot be made with certainty clinically, adrenal tumors commonly make their presence known by producing disturbance of adrenal function, such as paroxysmal hypertension, menstrual disturbances in the female, masculinizing effects or through invasion of the kidney they may cause hematuria late in their course. In this case there were no signs of symptoms pointing to the adrenal gland and it was only on examination of the x-ray plates that evidence of adrenal tumor was found. The clinical picture pointed almost entirely to pathology in the lungs.

CHRONIC NEPHRITIS AND HYPERTENSION— CLINICAL ASPECTS

(Continued from Page 13)

true uremia may respond quickly to improved kidney function and should be treated by salt restriction, fluid restriction, hot packs to both kidney regions, and sweat baths if well tolerated. The symptoms of a true uremia do not begin until the blood urea nitrogen reaches 150 mgm. or more.

In some cases, small cerebral accidents simulate symptoms of a true uremia, but the blood urea nitrogen will be below 150 mgm. This condition is sometimes called a "false" or "pseudo" uremia, and its chief importance is the liability of confusing

it with a true uremia. The patient, of course, may recover from this so-called pseudo-uremia in these chronic cases.

In conclusion, it may be stated that in nephritis, we are recognizing and understanding the condition better, but still are rather helpless to alter the course of the disease in the chronic cases. The use of the sulfanilamide derivatives in acute infections may reduce the frequency of acute nephritis and if so, of consequent chronic nephritis. In essential hypertension, the use of thiocyanate is of value and experimental work leaves us some hope of more specific treatment in the not too distant future.

NEWS NOTES

MILITARY DUTY

The following telegram was received from Dr. Olin West, Secretary of the American Medical Association, on January 16:

"I have been officially informed that because of constantly increasing demands on the Procurement and Assignment Service in Washington and because of the growing needs of the Army and Navy for personnel it has become necessary for a new form to replace the form that recently appeared in the Journal of the American Medical Association and that it is expected that the new form will be ready for release within the very near future. It is therefore requested that the form which appeared in The American Medical Association Journal and which was reproduced by official agencies of state associations in a number of states be discontinued. It is my understanding that complete information concerning the new form will soon be available. An expression of grateful appreciation of the splendid cooperation and helpful kindness of state and county committees and state secretaries is hereby extended in behalf of the American Medical Association and its Committee on Medical Preparedness. The Executive Officer of the Procurement and Assignment Service has today expressed to me similar appreciation on behalf of his office and of the Procurement and Assignment Service."

It is believed that the above change was authorized because considerable misunderstanding has existed concerning the use of the Procurement and Assignment Service questionnaire and that the new form is being prepared with a view toward clarifying the age group, specialties and similar questions.

Other information of interest recently published on this subject is as follows:

An editorial in the January 17 issue of the Journal of the American Medical Association:

"The questionnaires published in recent issues of The Journal elicited many thousands of replies. The requirements of military necessity do not permit stating the exact numbers of names which have been furnished to the Surgeon General at this time or the number who will be requested to come immediately into the service. Appreciation is tendered particularly to the secretaries of state medical societies and to the editors of state medical journals, who

gave complete cooperation in circularization of the appeal to the medical profession.

Under Medical Preparedness in this issue of The Journal appears a statement from the Procurement and Assignment Service regarding the present status of needs of the armed services and other federal agencies, and regarding also actions recently taken by the Board of the Procurement and Assignment Service for Physicians, Dentists and Veterinarians in relation to some questions that have been raised. Every physician in the United States is likely to find before the war is over that special need for his services in some capacity has arisen. The number of physicians to be called into the armed services is sufficiently great to dislocate much of the present status of medical practice. One needs only to point out that the expansion of the army by another million men would require at least seven thousand additional physicians. An army of four million men would necessitate a total of about thirty-two thousand physicians taken from civilian practice. Moreover, the call is primarily for men under thirty-six years of age and at most under forty-five years of age. On January 15 every medical reserve officer in a governmental department or agency and physically fit was notified that he would be considered available for active duty.

The whole purpose of the Procurement and Assignment Service for Physicians, Dentists and Veterinarians is to provide for the needs of the armed forces with the minimum amount of dislocation of medical service to civilian needs, including public health agencies, industrial plants and medical education. Another primary purpose is to place, as far as possible, men with special qualifications in duties for which they are particularly fitted. These purposes can be accomplished with the complete cooperation of the medical profession. Should the war be prolonged, however, from two to three years the majority of physicians under forty-five years of age who are physically fit will be engaged in the military services. Those who are not physically fit to meet the standards of the Army and the Navy will unquestionably be called on for additional services beyond the practices in which they are now engaged. The needs of civilian defense, industry and public health must be met. The procurement and Assignment Service plans to give to every physician who enrolls with that service for assignment a certificate and a numbered button to indicate that he has made himself available to the nation in this time of emergency. The medical profession can be depended on to do its utmost. Let us not fail!"

A statement issued by the Procurement and Assignment Service on January 17:

"At the time of the Pearl Harbor incident, December 7, 1941, the Army was short approximately fifteen hundred physicians to bring all existing installations up to war strength. Requisition was made on the Procurement and Assignment Service immediately to secure such physicians under the age of thirty-six. The number of physicians in the service was adequate to meet all professional demands in the care of patients but was not sufficient to provide physicians for all organizations on a war strength basis. Therefore the Procurement and Assignment Service on December 18 authorized the publication of application blanks for enrolment with a view to meeting the immediate needs of the Army. These blanks have been circulated by The Journal of the American Medical Association and by many state organizations. Some confusion has arisen in that many physicians interpreted the enrolment blank as another call for every physician in the United States to register. Actually, only those ready to volunteer for immediate service were wanted and only the applica-

tions of those capable of meeting specified qualifications are being forwarded.

The continued registration of all men under thirty-six who are immediately available for military duty in the Army or the Navy will suffice to meet the immediate needs of the military services, at least until completion of the roster system now being established in the office of the Procurement and Assignment Service.

Within sixty days the Procurement and Assignment Service expects to publish the physical requirements for service with every military, governmental, industrial and civil agency utilizing the services of physicians, dentists and veterinarians. Each physician, dentist or veterinarian will be asked to make a self analysis of his physical condition, so that he may himself determine with which of the agencies he is physically qualified to serve. Shortly thereafter the Procurement and Assignment Service expects to mail a new questionnaire and enrolment form. Each professionally qualified person will be asked to state, first, that he will volunteer his services in the interest of the national emergency; second, to state his first, second, third and fourth choice of the agencies which he will be willing to serve for the duration of the war. A list will be furnished of every military, governmental, industrial and civil agency requiring the services of physicians, dentists or veterinarians.

On self analysis of his physical condition, each man will be thus able to determine whether his physical fitness qualifies him for duty with the requisitioning agencies. On receipt of the enrolment form the Procurement and Assignment Service will issue a certificate of enrolment and a numbered button which will certify that the recipient has offered his services in the interests of the national defense. Thus, those who remain at home in an essential capacity will derive the satisfaction of knowing that they have offered their utmost to the national emergency and that this offer has been formally recognized by the Procurement and Assignment Service.

Sam F. Seeley, M.D.

Procurement and Assignment Service."

A statement issued by the Procurement and Assignment Service on January 19:

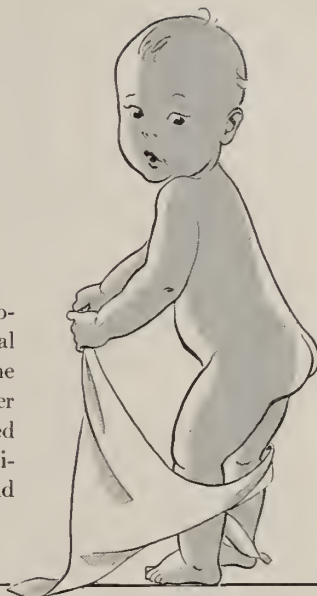
"Medical Students: A. All students holding letters of acceptance from the dean for admission to medical colleges and freshmen and sophomores of good academic standing in medical colleges should present letters or have letters presented for them by their deans to their local boards of the Selective Service System. This step is necessary in order to be considered for deferment in Class II-A as a medical student. If local boards classify such students in Class I-A, they should immediately notify their deans and if necessary exercise their rights of appeal to the Board of Appeals. If, after exhausting such rights of appeal, further consideration is necessary, request for further appeal may be made to the State Director and if necessary to the National Director of the Selective Service System. These officers have the power to take appeals to the President.

B. Those junior and senior students who are disqualified physically for commissions are to be recommended for deferment to local boards by their deans. These students should enroll with the Procurement and Assignment Service for other assignment.

C. All junior and senior students in good standing in medical schools, who have not done so, should apply immediately for commission in the Army or the Navy. This commission is in the grade of Second Lieutenant, Medical Administrative Corps of the Army of the United States, or Ensign H.V. (P) of the United States Navy Reserve,

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the choice as to Army or Navy being entirely voluntary. Applications for commission in the Army should be made to the Corps Area Surgeon of the Corps Area in which the applicant resides and applications for commission in the Navy should be made to the Commandant of the Naval District in which the applicant resides. Medical R.O.T.C. students should continue as before with a view of obtaining commissions as First Lieutenants, Medical Corps, upon graduation. Students who hold commissions, while the commissions are in force, come under the jurisdiction of the Army and Navy authorities and are not subject to induction under the Selective Service Act. The Army and Navy authorities will defer calling these officers to active duty until they have completed their medical education and at least twelve months of internship.

Recent Graduates: Upon successful completion of the medical college course, every individual holding commission as a Second Lieutenant, Medical Administrative Corps, Army of the United States, should make immediate application to the Adjutant General, United States Army, Washington, D.C., for appointment as First Lieutenant, Medical Corps, Army of the United States. Every individual holding commission as Ensign H.V. (P), United States Navy Reserve, should make immediate application to the Commandant of his Naval District for commission as Lieutenant (J.G.) Medical Corps Reserve, United States Navy. If appointment is desired in the grade of Lieutenant, (J.G.) in the regular Medical Corps of the United States Navy, application should be made to the Bureau of Medicine and Surgery, Navy Department, Washington, D.C.

Twelve Months Internes: All internes should apply for a commission as First Lieutenant, Medical Corps, Army of the United States, or as Lieutenant (J.G.), United States Navy or Navy Reserve. Upon completion of twelve months internship, except in rare instances where the necessity of continuation as a member of the staff or as a resident can be defended by the institution, all who are physically fit may be required to enter military service. Those commissioned may then expect to enter military service in their professional capacity; as medical officers; those who failed to apply for commission are liable for military service under the Selective Service Acts.

Hospital Staff Members: Internes with more than twelve months of internship, assistant residents, fellows, residents, junior staff members, and staff members under the age of forty-five, fall within the provisions of the Selective Service Acts which provide that all men between the ages of twenty and forty-five are liable for military service. All such men holding Army commissions are subject to call at any time and only temporary deferment is possible, upon approval of the application made by the institution to the Adjutant General of the United States Army certifying that the individual is temporarily indispensable. All such men holding Naval Reserve commissions are subject to call at any time at the discretion of the Secretary of the Navy. Temporary deferments may be granted only upon approval of applications made to the Surgeon General of the Navy.

All men in this category who do not hold commissions should enroll with the Procurement and Assignment Service. The Procurement and Assignment Service under the Executive Order of the President is charged with the proper distribution of medical personnel for military, governmental, industrial, and civil agencies of the entire country. All those so enrolled whose services have not been established as essential in their present capacities will be certified as available to the Army, Navy, governmental, industrial, or civil agencies requiring their services for the duration of the war.

All Physicians Under Forty-Five: All male physicians in

this category are liable for military service and those who do not hold commissions are subject to induction under the Selective Service Acts. In order that their service may be utilized in a professional capacity as medical officers, they should be made available for service when needed. Wherever possible, their present positions in civil life should be filled or provisions made for filling their positions, by those who are (a) over forty-five, (b) physicians under forty-five who are physically disqualified for military service, (c) women physicians, and (d) instructors and those engaged in research who do not possess an M.D. degree whose utilization would make available a physician for military service.

Every physician in this age group will be asked to enroll at an early date with the Procurement and Assignment Service. He will be certified for a position commensurate with his professional training and experience as requisitions are placed with the Procurement and Assignment Service by military, governmental, industrial or civil agencies requiring the assistance of those who must be dislocated for the duration of the national emergency.

All Physicians Over Forty-five: All physicians over forty-five will be asked to enroll with the Procurement and Assignment Service at an early date. Those who are essential in their present capacities will be retained and those who are available for assignment to military, governmental, industrial or civil agencies may be asked by the Procurement and Assignment Service to serve those Agencies.

The maximal age for original appointment in the Army of the United States is fifty-five. The maximal age for original appointment in the Naval Reserve is fifty years of age. Sam Seeley, M.D., Procurement and Assignment Service.

It is understood that the medical corps of the Army and the Navy have available at the present time a limited number of commissions of higher rank which are being offered on application to physicians up to forty-five years of age who can fulfill certain specialty and other requirements desired.

OBSTETRICAL MEETING

On Monday, February 2, 1942, the Kansas Obstetrical and Gynecological Society will hold its third educational meeting of the year at the Jayhawk Hotel in Topeka.

This meeting is in conjunction with the regular meeting of the Shawnee County Medical Society. Dinner will be served at 7:00 p.m., and at 8:00 p.m. Dr. Norman R. Kretschmar of the University of Michigan will talk upon "Asphyxia Neonatorum." His talk will be illustrated by Kodachrome movies.

All members of The Kansas Medical Society are invited to attend this meeting. If you expect to attend the dinner, please make reservations with Dr. L. R. Pyle, 415 Mills Building, Topeka.

DUES

The following bulletin was mailed to the secretaries of all county medical societies on December 20, 1941:

"As is customary at the end of each year, we have enclosed a copy of the official membership report for your society. The front side of the report may be used for the listing of members and the reverse side is provided for the listing of ineligible and other physicians in your county.

The State Society dues for 1942 will be \$15.00 per member which, as you know, is in accordance with the action taken by the House of Delegates at the last annual session. Any local dues desired by your society may, of course, be added to that amount.



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Members serving in the military forces will be exempt from the payment of State Society dues on the basis outlined in the following resolution adopted by the Council on February 9, 1941.

"On and after January 1, 1941, members of the Society who are engaged in full-time active duty with the United States Army, Navy or Marine Corps may, upon the request of their county medical society, be exempted from payment of Society dues for the period that they are engaged in such full-time active duty.

"Exemption from payment of dues shall be prorated upon a monthly basis equal to one-twelfth of the total annual dues assessed by the Society for the period of exemption which commences on the first day of the month following entrance into full-time active service and terminates on the first day of the month following return to a civilian status."

In order that our records may be correctly maintained, we would appreciate your listing all members of your society serving in the military forces in the membership column of the enclosed report under a heading of "members engaged in military duty." As you know, physicians within this category, will be listed as members of the Society for 1942, and will be entitled to all services of the organization.

The issuance of membership cards in addition to our other work presents a considerable task for the central office, and thus if some delay occurs in the handling of your report we ask your forgiveness.

We realize that the collection of dues occasions many difficulties for the secretaries of county medical societies, and we assure you that the Society is particularly appreciative of your assistance in this regard. If there is any way in which we can help we shall be happy to have you call upon us."

TIRE PRO-RATIONMENT

The recent regulation issued by the Office for Emergency Management of the Price Administration in Washington, in regard to the sale of automobile tires, contains the following provision pertaining to physicians:

"On a vehicle which is operated by a physician, surgeon, or visiting nurse, or a veterinary and which is used principally for professional service, the local board shall issue certificates for vehicles in this class only to doctors, nurses and veterinaries (which for purpose of certificates shall include only farm veterinaries) whose professional practice is to make regular calls outside their offices, and use automobiles to make their professional calls.

No certificate shall be issued unless the doctor, nurse, or farm veterinary applying shows that the particular car on which the tire or tube is to be mounted is actually used for professional calls and is used principally for that purpose."

Excerpts of other information contained in the regulations are as follows:

"Rubber is indispensable to the successful prosecution of the war in which the United States is now engaged—both in the firing line and on the home front. . . . The stockpile, which it contains the largest amount of rubber ever held in the United States, would be exhausted in less than one year if normal civilian consumption were allowed to continue. To conserve our rubber supply and to make possible the continuance of transportation service vital to the Army and Navy, to industrial production, and to civilian

life, the Office of Production Management has issued a series of orders. . . . The Office of Production Management delegated the Office of Price Administration the function of distributing the very limited supply of rubber tires which can be made available for civilian use among those persons and enterprises which must be assured transportation if the community is to remain safe, healthy and productive. The Tire Rationing Board, selected by State and local councils of defense, . . . are charged with the particularly important duty of distributing the supply of rubber tires to cover the most essential needs in their communities."

"The regulations require persons seeking to purchase tires to apply to the local boards for permission to purchase tires. Application forms are necessarily fairly elaborate and detailed documents. Upon the basis of the information given in them, the local boards must decide whether the applicant wants tires for a reason sufficiently important to the community to justify giving him a share in the all-important supply of rubber. If the local board has tires available under its quota and decides that the application is warranted, it will grant the applicant a certificate entitling him to purchase tires."

SELECTIVE SERVICE

The Kansas State Selective Service headquarters has announced that the new plan for physical examinations of selective service registrants is now in operation in all counties of the State.

The new plan is in the nature of a screening examination and replaces the detailed examination formerly provided by the county selective service boards.

Under the new plan the medical examiners for the county boards ascertain only those having irremedial physical defects and these are eliminated. The complete physical examination of tentatively approved registrants is then provided at the induction board centers.

The change in the method of examination was made with the hope of expediting selective service procedure thru the provision of one rather than two complete examinations.

NATIONAL CONFERENCE

The annual meeting of the National Conference on Medical Service will be held at the Palmer House in Chicago on February 15, commencing at 9:30 a.m. The program for the meeting is as follows:

The Relation of the Physician to Military, Civilian and Industrial Health; Procurement and Assignment of Physicians for Military Service—Sam F. Seeley, M.D., Executive Officer, Procurement and Assignment Service, Washington, D.C.

Civilian Defense, Hospitals and Emergency Medical Squads—Graham L. Davis, Hospital Consultant, W. K. Kellogg Foundation, Battle Creek, Michigan.

Industry's Problem in Maintaining Adequate Medical Care; Non-Defense Projects—John R. Nilsson, M.D., Chief Surgeon, Union Pacific Railroad, Omaha, Nebraska.

National Defense Projects—W. D. Norwood, M.D., Medical Director, DuPont Company, Elwood Ordinance Plant, Joliet, Illinois.

The Role of the State Medical Society and State and City Departments of Health in National Defense; State Medical Society—W. P. Wheery, M.D., President Nebraska State

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State Department of Health—W. L. Bierring, M.D., State Health Officer of Iowa, Des Moines, Iowa.

City Health Department—Herman N. Bundesen, M.D., President, Board of Health, Chicago, Illinois.

President's Address—Harold M. Camp, M.D., Monmouth, Illinois.

Report of Nominating Committee; Annual Election of Officers; Selection of Place for 1943 Meeting.

Rejected Selectees and Their Rehabilitation for Active Military Service; Local and Induction Board Examinations—Samuel J. Kopetzky, M.D., New York City.

One Million Rejected; What Percent May Be Salvaged; By Personal Physician or Dentist Prior to Induction—George Baehr, M.D., New York City and J. R. Blayner, D.D.S., Chicago, Illinois.

Following Induction—L. D. Redway, M.D., Ossining, New York.

The Role of the Medical, Dental, Nursing Schools and Hospitals in Anticipating the Acceleration of Training; The Need for a Trained Personnel to Care for the Health of the Military—J. R. Darnall, M.D., Lt. Colonel, Medical Corps, Washington, D.C.

Status of Pre-Medic, Medic and Dental Students, Internships and Residencies During the Emergency—Leonard Roundtree, M.D., Chief, Medical Division, Selective Service, Washington, D.C.

What the Medical, Dental and Nursing Schools May Do to Hasten the Graduation of their Respective Students—Fred C. Zapffe, M.D., Chicago, Illinois.

APPOINTMENT

Announcement was recently made in Washington that Dr. F. L. Loveland of Topeka has been appointed as a member of the Seventh Corps Area Committee on Procurement and Assignment.

Committees of this kind have been appointed in each of the nine Corps Areas. Each of the committees will consist of three representatives of the medical profession, one representative of the dental profession, one representative of the veterinary medical profession, one representative of medical schools, and one representative of hospitals. It is understood that the committees will assist the Procurement and Assignment Service in Washington in obtaining adequate medical personnel for the Army and Navy and in attempting to provide adequate facilities for civilian needs.

WOMEN'S FIELD ARMY

The executive committee of the Kansas Women's Field Army for Control of Cancer recently announced that Mrs. J. E. Johntz of Abilene has been appointed as the State Commander of the organization.

Mrs. Johntz takes the place of Mrs. Donald Muir of Anthony who resigned her place as State Commander in order that she might accept an appointment as Deputy Commander in the national organization of the Women's Field Army.

Mrs. Johntz is well known to many physicians in the State. She has had a vast amount of experience in national, state, and local organization work with the Federation of Women's Clubs and she has been active in numerous other organizations. She has served as Deputy Commander of the Kansas Women's Field Army for the past several years and thru that and other activities is well acquainted with the various aspects of cancer lay education. The Kansas

medical profession welcomes her to her new position and will be happy to assist her in any way it can, in the execution and furtherance of this very valuable program.

MEDICAL PRACTICE VIOLATOR

A hearing was held in the District Court of Doniphan County on January 5 in regard to a citation for contempt of court filed against E. B. Martin of Wathena.

The Court found Martin guilty of contempt and sentenced him to a fine of \$100.00 and sixty days in the county jail.

Martin, who does not hold any form of license in this State, was enjoined against the further practice of medicine and surgery by the above Court on November 1940.

He thereafter, left the State but returned in May 1941 and again engaged in the practice of medicine.

The citation for contempt was filed by the Kansas State Board of Medical Registration and Examination. Mr. Theo F. Varner of Independence, attorney for that Board, assisted in handling the case.

F. S. A. MEDICAL PLANS

The Northwest Kansas Medical Society and several other medical societies have recently announced that the Farm Security Administration Medical Plans in those areas have been or are to be terminated within the near future.

It is understood that mutual agreements have been made between Farm Security clients, the Farm Security Administration and the medical societies, that the plans were intended to serve only during emergency needs, that the emergency no longer exists, and that, therefore, medical services for these individuals can now be continued without the use of the plans.

LOCAL HEALTH SERVICE DIRECTOR

The Kansas State Board of Health recently announced the appointment of Dr. Henry H. Asher as Director of the Division of Local Health Service in the State office.

The director of this division assists the county health officers in the performance of their duties. The position was formerly held by Dr. Richard F. Boyd who resigned during last November to accept a position with the Farm Security Association in Wisconsin. Dr. Asher has served as County Health Director in Sedgwick County during the past two years.

NEW LICENSEES

The Kansas State Board of Medical Registration and Examination held its regular mid-winter examination in Topeka on January 9-10.

The Board subsequently announced that licenses have been issued to the following physicians:

Glenn Carl Bond, Lawrence, Kansas.

William Hammack Goodson, Jr., Kansas City, Missouri.

William Samuel Levy, Woonsocket, Rhode Island.

Harry Cofman Wolohon, West Mineral, Kansas.

James Francis Zagaria, Topeka, Kansas.

The number of applicants for the mid-winter examination was smaller than usual due to the fact that a special examination was given last September to the graduates of the University of Kansas School of Medicine. The special examination was given in conjunction with the medical



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The next examination to be given by the Board will be held at the Wyandotte High School in Kansas City, Kansas on June 16-17.

COMMITTEE ON LAND USE

The subcommittee on health of the Kansas Committee on Land Use presented the following recommendations which were adopted in full by the general committee at a meeting of that organization held in Manhattan on November 20-21:

"A. Housing in Relation to Health

We recommend that:

1. This is the time for people on the farm to make life more attractive to themselves and their children by making their homes more conducive to good health. In view of the fact that there will be increased incomes from farm products, farm families should be urged to improve their homes with water facilities, septic tanks, bathing facilities, and other equipment which are not vitally necessary to defense, as long as these improvements are not purchased on credit.

2. Exhibits and demonstrations of home-produced wool used for bedding be given in area meetings in areas where sheep are raised. The Extension Service will be responsible for setting up these exhibits.

B. Preventive Medicine in Relation to Health

We recommend that:

1. A letter be written to the chairman of the legislative committee on tuberculosis, complimenting the committee on its study and work with the tuberculosis problem of southeastern Kansas and the State as a whole.

2. Re-emphasis of the following recommendation contained in the revised Unified State Agricultural Program:

"That each county committee study the plans and arrangements utilized in their counties for the provision of indigent medical care, that assistance be provided in acquainting county boards of social welfare with the importance of having complete and workable plans for this purpose, and that in areas where additional physicians are deemed to be needed particular study and effort be devoted to this subject."

3. Each 4-H Club and women's Extension group in the State arrange to present at least one program on medical and health matters each year and that Extension Division assist these groups where desired in the selection of subjects and in the provision of speakers for this purpose. (Supplements Paragraph C, 1, g of the revised Unified State Agricultural Program.)

4. The study of health facilities and resources in Kansas being made by the Bureau of Agricultural Economics and the State Agricultural Experiment Station of Kansas be extended to include a more detailed study in existing problem areas and that representative counties in these areas be selected for intensive study.

This committee expresses interest in the tentative plan for group hospitalization being sponsored by the Kansas Hospital Association and recommends that the plan be approved with the understanding that it will be developed in conformity with the conditions required by the American Hospital Association and the State Commissioner of Insurance.

Accomplishments:

1. Letters have been written to the United States Army Medical Corp, Seventh Corps Area, Omaha, Nebraska requesting that due to the need of medical facilities of many areas in Kansas, doctors of medicine who practice in such

areas be deferred or in cases of reserve officers that they have the privilege of resigning.

It is believed that this problem has been worked out satisfactorily and that the Army is cooperating. It is probably true that Kansas is not confronted with an immediate emergency.

2. Relative to recommendation C, 2, e of the revised Unified State Agricultural Program, the Kansas Medical Society reports that progress is being made relative to studies of mileage charges for medical service. Efforts in this direction are being continued.

3. Relative to recommendation C, 1, f of the revised Unified State Agricultural Program, Lyon County is experimenting with a special plan for medical attention.

C. Nutrition in Relation to Health

We recommend that:

1. The Works Progress Administration be mindful of the need for training their clients in the use of surplus commodities, and that their clients be urged to take advantage of local health programs where they can get information concerning the use of these foods.

2. The Extension Service should help promote this program by making arrangements for meetings in rural areas for Works Progress Administration clients.

3. Local school lunch committees be commended for the fine work they have done and that farm people be urged to get behind the school lunch program.

4. A letter of commendation be sent to the federal government urging continuance of surplus commodities for school lunch purposes and emphasizing the value of the school lunch and food stamp plans.

5. The Extension Service put on an intensive home food production campaign, in support of the defense program to the end that the 115,900 garden goal be reached in 1942.

6. Gardens be included for practice payments in the regular AAA Docket to encourage accomplishment of the 115,900 garden goal."

The Kansas Committee on Land Use is composed of representatives from the various parts of the State, of county farm bureaus, extension service specialists, federal agencies and other organizations and individuals interested in farm problems. The committee thru various subcommittees prepares recommendations for programs of interest to farmers and farm families.

MINUTES

The following are the minutes of recent meetings of the Council and of the Committee on Industrial Medicine:

A joint meeting of the Council and the Committee on Public Policy was held in Topeka on November 30.

Officers and members of the Council present were: Dr. C. D. Blake of Hays; Dr. H. N. Tihen of Wichita; Dr. O. A. Hennerich of Hays; Dr. J. L. Lattimore of Topeka; Dr. G. O. Speirs of Spearville; Dr. Philip W. Morgan of Emporia; Dr. Herbert Atkins of Pratt; Dr. J. M. Porter of Concordia; Dr. F. R. Croson of Clay Center; Dr. L. S. Nelson of Salina; Dr. J. H. A. Peck of St. Francis; and Dr. O. W. Davidson of Kansas City. Members of the Committee on Public Policy present were: Dr. F. L. Loveland of Topeka; Dr. E. C. Duncan of Fredonia; Dr. J. F. Hassig of Kansas City; Dr. L. L. Bresette of Kansas City; Dr. F. S. Hawes of Russell; Dr. J. B. Carter of Wilson; Dr. H. A. Hope of Hunter; Dr. B. A. Higgins of Sylvan Grove; Dr. C. A. Dieter of Harper; and Dr. W. F. Bernstorff of Winfield. Others present were: Dr. Walter Stephenson of Norton; Dr. C. E. Joss of Topeka; Mr. Kirke W. Dale of Ar-

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kansas City; Mr. Theo. F. Varner of Independence, and Mr. Clarence G. Munns.

A meeting of the Council was held in advance of the meeting with the committee, at which the following matters were considered:

The proposals pertaining to obstetrical rules and mothers' training classes submitted to the Council by the Committee on Maternal Welfare was tabled until a later meeting, inasmuch as Dr. Ray West, the chairman of the Maternal Welfare Committee, was unable to be present for discussion of these matters.

A report was made concerning the Kansas State Committee on Land Use, of its interest in public health and medical programs pertaining to farm families, and of its request that the Society attempt to find a better basis of fees for farm home calls than the present mileage system. After discussion of mileage charges and other fees for services to farm families, it was agreed upon a motion made, seconded and carried, that the Medical Economics Committee should be asked to meet with the health subcommittee of the Kansas State Committee on Land Use to discuss this subject and that if the Medical Economics Committee desires for any other members to assist in this regard, it should be authorized to make the necessary arrangements.

Dr. Blake outlined the information which has been received to date pertaining to the new plan for provision of physical examinations for Selective Service registrants, and which is expected to be instituted within the near future, and also as to the contemplated program for rehabilitation of rejected registrants.

Dr. Tihen presented a report about the plans which are being made for the 1942 annual session, and stated that he believes satisfactory progress is being made in this regard. Upon a motion made, seconded and carried, the usual guarantee of Society financial assistance, to defray the cost of the meeting in the event such is necessary, was authorized.

Dr. Blake reported that the Kansas Medical Auxiliary is confronted with certain problems by reason of a deficit in its finances and that the officers of the Auxiliary have stated they would greatly appreciate any assistance the Society can provide in this connection. Upon a motion made, seconded and carried, the Council expressed sentiment that financial assistance should be provided to the Auxiliary for this purpose, and the Executive Committee was authorized to designate the amount of this assistance, after discussion of the matter with the officers of the Auxiliary.

Dr. Blake commented on the location problem in this State and on the need for the Councilors to keep this matter in mind and to assist therein in all ways possible.

Clarence Munns presented a report on the progress which has been made to date for the institution of a group hospitalization program in this State.

Dr. Lattimore described certain plans which have been suggested to the Kansas State Board of Health for the certification and approval of clinical laboratories. Upon a motion made, seconded and carried, the Committee on Venereal Disease was asked to study these proposals and to prepare a report therein for consideration by the Council.

Dr. Nelson stated that the Defense Board feels certain changes should be made in the present method of providing Society defense assistance, and that it is considering the possibility of introducing an amendment to the by-laws at the next annual session wherein the following changes would be made:

That members applying for defense assistance would be expected to provide their own primary defense.

That the Defense Board would provide advisory and secondary assistance rather than the type of assistance now provided.

After discussion of possible advantages and disadvantages presented in this arrangement, it was agreed that the Defense Board should present a report and recommendations on this general question at the next meeting of the House of Delegates.

A motion was made, seconded and carried, wherein Dr. Morgan was asked to serve as a committee of one on behalf of the Council to convey the regards and well wishes of the Society to Dr. C. C. Stillman.

The Council then resolved itself into joint session with the Committee on Public Policy wherein the plans of that committee for the next year were discussed.

Adjournment followed.

COMMITTEE ON INDUSTRIAL MEDICINE

A meeting of the Committee on Industrial Medicine was held at Wichita on November 23.

Members of the committee present were: Dr. C. R. Rombold of Wichita, chairman; Dr. G. E. Kassebaum of ElDorado, Dr. C. C. Nesselrode of Kansas City, and Dr. H. L. Regier of Kansas City. Guests present were: Mr. Erskine Wyman of Topeka, State Compensation Director; Mr. George Powers of Wichita and Mr. Hughes Cunningham of Wichita. Mr. Clarence G. Munns was present as Executive Secretary.

Dr. Rombold presented a description of the program on industrial medicine and workmen's compensation which the Committee on Industrial Medicine of the American Medical Association has recommended be accomplished in each state. He commented, also, on the fact that this committee is a new activity of the Society; that it is believed there are many matters in which the committee can provide assistance, and that Mr. Wyman, Mr. Cunningham, and Mr. Powers had been invited to attend the meeting for suggestion and discussion of possibilities in that connection.

Dr. Rombold then asked Mr. Wyman to make any comments he desired to make. Mr. Wyman expressed his appreciation for the assistance the Society furnished in the preparation of the new physical examination report which was recently adopted by the Kansas Workmen's Compensation Commission. He stated, also, that he believed the committee can provide very helpful assistance in the following matters:

1. That study be given to the present Kansas Workmen's Compensation fee schedule to determine whether any revision should be made therein from the standpoint of fees which are obsolete or otherwise out of line with current practices.

2. That the committee assist in urging physicians to handle workmen's compensation correspondence promptly in order that help may be provided to insurance companies and the other agencies interested in that subject.

3. That it might be helpful for physicians to be furnished with a pamphlet showing the procedure which is followed in the handling of workmen's compensation cases in this State, and the matters covered by the Kansas Workmen's Compensation law, and that he would be very happy to assist in any way desired in that connection.

4. That consideration be given to ways and means wherein standardization of the rating of workmen's compensation disabilities can be furnished.

Following discussion of these matters, Dr. Rombold asked Mr. Cunningham to present any suggestions he cared to make. Mr. Cunningham commented as follows:

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**J.A.M.A.*, 93:1110, October 12, 1929

Bruckner, Die Biochemie des Tabaks, 1936

***The Military Surgeon*, Vol. 89, No. 1, p. 7, July, 1941

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1. That he felt physicians are frequently burdened with the necessity of preparing lengthy examination reports in cases where such is unnecessary and that it might be possible for a more brief form to be used for this purpose.

2. That his experience as a member of workmen's compensation adjustment firm has been that Kansas physicians are fair and reasonable in their charges for compensation cases and that he is certain all industries, insurance companies and adjustment firms have greatly appreciated this assistance.

3. That insurance companies are obligated to pay compensation settlements without delay and that physicians can be of particular assistance in that regard by handling settlement correspondence promptly.

4. That the charts used in conjunction with the physical examination form should be carefully and completely filled out, inasmuch as they are of importance in the handling and payment of claims.

Dr. Rombold then called upon Mr. Powers for his suggestions. Mr. Powers stated that in his capacity as an attorney handling compensation cases he had had an opportunity to observe certain medical matters pertaining to that subject and that he agreed in the suggestions which had been made by the preceding speakers. He stated, also, that he felt the committee could accomplish much help in the following matters:

1. The preparation of recommendations for revision of the present workmen's compensation fee schedule.

2. A program of information for physicians on various industrial medical matters.

After additional discussion, it was decided that the committee would attempt to accomplish the following program during the next year:

1. That Mr. Wyman be requested to prepare a pamphlet on articles outlining workmen's compensation procedure in this State and the matters covered in the Kansas Workmen's Compensation law: that this be published in the Journal; and that it also be distributed in pamphlet or bulletin form to the members of the Society.

2. That Mr. Wyman and Dr. Rombold confer about possibilities for preparing a revision of the present Kansas

Workmen's Compensation fee schedule.

3. That a pamphlet be prepared wherein would be included the Kansas Workmen's Compensation fee schedule, an abstract of the Kansas Workmen's Compensation law, suggestions as to the handling of workmen's compensation cases, comments on the industrial medical needs in this State, suggestions on ways and means for preparing estimates of disability, and other similar information, and that this be forwarded to all physicians in the State. A suggestion was also made that a subcommittee of the committee be appointed by the chairman for the preparation of a pamphlet of this kind.

4. That consideration be given to the possibility of the committee sponsoring a post graduate course on industrial medicine during the next year at some central place in the State; that the course presented this year should be of one day's duration; and that the chairman be requested to make inquiry concerning speakers who can be obtained and other arrangements for this purpose.

The central office was asked to discuss with Mr. Wyman the possibility of the Kansas Workmen's Compensation Commission presenting an exhibit at the next annual session of the Society.

Adjournment followed.

COUNTY SOCIETIES

The Central Kansas Medical Society held its quarterly meeting in Hays at the St. Anthony Hospital on December 12. Dr. O. A. Hénnerich of Hays showed movies on pneumonia and appendicitis at the afternoon session. Speakers for the evening session were: Dr. John M. Porter, of Concordia, who spoke on "The Use and Abuse of Drugs in Heart Disease" and Dr. Henry N. Tihen of Wichita who discussed "A Gastroenterological Review." The following officers were elected for the new year: Dr. H. R. Bryan of Hays as President; Dr. Earl F. Morris of Hays as Vice-President; Dr. P. S. Brady of Hays as Secretary-Treasurer; Dr. C. O. Hoover of Quinter as a member of the Board of Censors and Dr. Clair O'Donnell of Ellsworth as Delegate.

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The Crawford County Medical Society held election of officers at its meeting held in Pittsburg on December 23. Dr. C. H. Benage of Pittsburg was elected as President; Dr. E. J. Schulte of Girard as Vice-President; and Dr. C. D. Bell of Pittsburg as Secretary-Treasurer. Dr. Benage gave a talk on "Gall Bladder Diseases." The next meeting of the society will be held on January 29.

The Douglas County Medical Society elected the following officers at a meeting held in Lawrence on December 3: Dr. R. B. Hutchinson of Lawrence as President; Dr. M. D. Ballard of Baldwin as Vice-President; Dr. Wray Enders of Lawrence as Secretary; Dr. E. M. Owen of Lawrence as Treasurer; and Dr. R. A. Schwegler, Jr., of Lawrence and Dr. R. H. Edminston of Lawrence, as members of the Board of Censors.

The Franklin County Medical Society held a special meeting on January 11, in Ottawa, to discuss the subject of Medical Procurement and Assignment Service and emergency medical civilian defense needs in the country. The following officers were also elected for 1942: Dr. F. A. Trump of Ottawa as President; Dr. J. F. Barr of Ottawa as Vice-President; Dr. P. R. Young of Ottawa as Treasurer; and Dr. M. E. Kaiser of Ottawa as Secretary.

The Geary County Medical Society met in Junction City on December 15 and elected the following to office for the new year: Dr. A. E. O'Donnell of Junction City as President; Dr. C. V. Minnick of Wakefield as Vice-President and Dr. L. S. Steadman of Junction City as Secretary-Treasurer.

The Harvey County Medical Society held a dinner meeting in Newton on December 1. Dr. F. W. Koons of Halstead spoke on "The Treatment of Scarlet Fever with Sulfonilamide." The following officers were elected at the meeting: Dr. John W. Hertzler of Newton as President; Dr. Paul W. Miles of Newton as Vice-President; and Dr. C. T. Sills of Newton as Secretary-Treasurer.

The Labette County Medical Society and Auxiliary were entertained with a dinner at the home of Dr. and Mrs. M. C. Ruble of Parsons on December 17. An election of officers was held following the dinner. Dr. Charles H. Miller of Parsons was elected as President; Dr. T. D. Blasdel of Parsons as Vice-President; and Dr. Guy Cramer of Parsons as Secretary-Treasurer.

The McPherson County Medical Society met in McPherson on December 10. The following were elected as officers to serve during the next year: Dr. C. R. Lytle of McPherson as President; Dr. Cora Dyck of Moundridge as Vice-President; and Dr. A. M. Lohrentz of McPherson as Secretary-Treasurer. Dr. John Green, who has spent several years in China, discussed medical practice in that country.

The Kingman County Medical Society held a dinner in Kingman on December 4. The following members were elected as officers for the next year: Dr. Ferd Burnett of Cunningham as President, Dr. H. E. Haskins of Kingman as Secretary-Treasurer.

The Montgomery County Medical Society entertained the wives of its members with a banquet in Coffeyville on December 18. Dean W. M. Ostberg of the Coffeyville Junior College was a speaker at the meeting. The following new officers were also elected: Dr. J. D. McMillion of Coffeyville as President; Dr. Porter M. Clark of Independence as Vice-President; Dr. I. B. Chadwick of Coffeyville as Secretary; Dr. C. C. Bates of Independence as Treasurer; and Dr. H. L. Bagby of Coffeyville as a member of the Board of Censors.

The Nemaha County Medical Society met in Sabetha on December 16 to discuss medical civilian defense activities for that county. New officers elected at the meeting were as follows: Dr. Clemens Rucker of Sabetha as President; Dr. Bernice Havley of Centralia as Vice-President; Dr.



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V. E. Brown of Sabetha as Secretary-Treasurer, and Dr. Sam Meyer of Corning as Delegate.

The Northwest Kansas Medical Society was entertained with a dinner by the staff of the Thomas County Hospital in Colby on December 17. Dr. Mahlon Delp of the University of Kansas School of Medicine spoke on "Coronary Heart Disease." The following officers of the society were elected for next year: Dr. Walter Stephenson of Norton as President; Dr. C. E. Henneberger of Atwood as Vice-President; and Dr. W. E. Stone of Norton as Secretary-Treasurer.

The Members of the Pratt County Medical Society entertained their wives at a dinner meeting held in Pratt on December 12. New officers elected at the meeting were as follows: Dr. J. R. Cambell of Pratt as President, and Dr. M. D. Christmann of Pratt as Secretary-Treasurer.

The Sedgwick County Medical Society met in Wichita on December 2. Dr. Paul Reznikoff, Assistant Professor of Clinical Medicine at Cornell Medical School, spoke on "Hematologic Problems in General Practice". The society also elected the following officers for 1942 at the meeting: Dr. Charles Rombold as President; Dr. E. E. Tippin as Vice-President; Dr. Earl Mills as Treasurer; Dr. H. F. O'Donnell as Secretary; Dr. George Cowles, Dr. A. P. Gerhart, Dr. C. A. Hellwig, Dr. F. J. McEwen, Dr. N. L. Rainey, Dr. R. A. West, Dr. F. L. Menehan and Dr. B. P. Meeker were elected to the Board of Directors.

The Shawnee County Medical Society and the Golden Belt Medical Society held a joint meeting in Topeka on January 8. Lt. Col. Seth A. Hammel of Topeka spoke on the "Medical Aspect of Selective Service"; Dr. Leo A. Smith of Topeka spoke on "Rectal Fissure"; Dr. Harry J. Davis of Topeka spoke on "Body Fluid"; Dr. W. J. Walker of Topeka spoke on "Peptic Ulcer", and Dr. L. R. Pyle of Topeka discussed a "Case Report of Pregnancy with Un-

usual Complications". Dr. Davis presented colored movies of deep sea fishing in Mexico.

The Wilson County Medical Society entertained the wives of its members at a dinner meeting held in Fredonia on November 10. The following officers were elected at the meeting: Dr. O. D. Sharp of Neodesha as President; Dr. F. A. Moorhead of Neodesha as Vice-President; and Dr. E. C. Duncan of Fredonia as Secretary-Treasurer.

The Washington County Medical Society met on December 9 in Washington, at which time the following were elected to office: Dr. H. G. Hurtig of Hanover as President; Dr. R. G. Gomel of Washington as Vice-President; and Dr. Lynn J. L'Ecuier of Greenleaf as Secretary-Treasurer.

The Wabaunsee County Medical Society met in Eskridge on January 2. Dr. E. B. McKnight of Alma was elected President of the society and Dr. A. A. Meyer of Alma was elected Secretary-Treasurer.

The Wyandotte County Medical Society met on December 16 in Kansas City and elected the following officers for next year: Dr. Thomas J. Sims of Kansas City as President; Dr. Donald Medearis of Kansas City as Vice-President; Dr. Maurice J. Ryan of Kansas City as Secretary; Dr. P. E. Hiebert of Kansas City as Treasurer; Dr. C. E. Coburn of Kansas City as a member of the Board of Censors, Dr. M. A. Walker and Dr. E. F. DeVilbiss both of Kansas City as Delegates.

MEMBERS

Dr. Ernest Seydell of Wichita presented two papers before the meeting of the Southern Medical Association which was held in St. Louis, November 10-13, 1941. Dr. Seydell spoke on "Influence of the Varieties in Size and Structure of the Lateral Sinus Upon the Clinical Manifesta-

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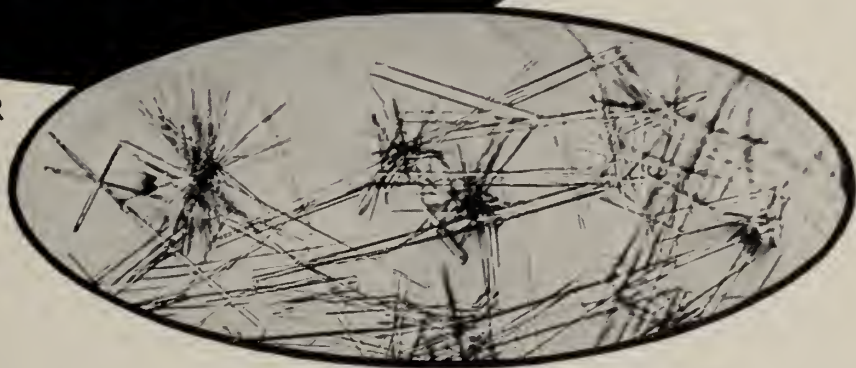
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The American Board of Internal Medicine recently announced that Dr. F. L. Loveland of Topeka has been made a Diplomate of that Board.

Dr. Henry S. Blake, formerly of Topeka and recently of the Harper Hospital of Detroit, Michigan, is now associated with Dr. W. M. Mills of Topeka.

Dr. James A. Wheeler of Newton is the author of a clinical report on "Western Equine Encephalitis Occurring Among Human Beings in Kansas During the Summer of 1941", which was published in The Journal of the American Medical Association for December 6, 1941.

DEATH NOTICES

Dr. Tasso O. Felix, 80 years of age, formerly of Downs, died on December 12 in Denver, Colorado. Dr. Felix was born in Holt County, Indiana, on March 21, 1861. He was graduated from the Marion-Sims College of Medicine of St. Louis, Missouri, in 1898 and was a member off the Osborne County Medical Society.

Dr. Clinton D. Vermillion, 73 years of age, of Tescott, died on December 27 in Salina. Dr. Vermillion was born at Parkville, Missouri, on September 10, 1868, and was graduated from the College of Physicians and Surgeons of Kansas City in 1901. He was a member of the Saline County Medical Society.

Dr. Charles L. Mosley, 55 years of age, died of carcinoma of the lung on November 25 at Fort Scott. Dr. Mosley was born in Stanberry, Missouri, on August 13, 1886. He was graduated from the Barnes Medical College of St.

Louis, Missouri, in 1908 and served as a Lieutenant in the Medical Corps of the United States Army in France during the last war. He was a member of the Bourbon County Medical Society.

KANSAS MEDICAL ASSISTANTS

An informal meeting of the Executive Committee to the Kansas Medical Assistants Society was held in Topeka on December 6. Miss Katherine Fleetwood of Wichita was appointed as Assistant Corresponding Secretary to fill the unexpired term of Miss Joyce Ryerson who recently resigned because of illness. A charter was granted to the Atchison County Medical Assistants Society, who have thirteen members.

The Sedgwick County Medical Assistant Society held installation of the following officers at its meeting held in Wichita on December 17: Miss Thelma Gelbach as President; Miss Virginia Kaelson as Vice-President; Mrs. Charlotte Parrish as Secretary and Miss Zura Crockett as Treasurer. Miss Kathryn Millsap, Deaconess of Wesley Hospital in Wichita spoke on Hospital Work. The next meeting of the society will be held in Wichita on January 21, at which Mr. W. M. Moberly, a certified public accountant, will be a speaker.

The Ford County Medical Assistants Society met recently for a turkey dinner at the home of Miss Lois Clapper in Dodge City. The next meeting will be held in January.

The Cowley County Medical Assistants Society held a meeting in Winfield on January 16.

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AUXILIARY

PRESIDENT'S MESSAGE

As your President, I visited several of the auxiliaries during the days between December 7 and 9. Everywhere I found the members interested in the constructive programs of the auxiliary. I was greatly impressed with the growing spirit of intimate friendship among the doctors' wives. This feeling not only encompassed co-operation but is a down-to-the-earth neighborliness which displays itself in a keen interest in the happiness, disappointments, and successes of each individual family. It is a heart warming experience to work with such women.

Since my last letter to you, our country has declared war, and I realize that many of these fine homes, expressive of the back-bone of American civilization, will be sending their doctor—husbands and sons into service. On December 29 Dr. C. H. Warfield, the husband of our State Auxiliary Secretary was called from his home. We know that there are others and we hope that the secretary of each auxiliary will send in a list of these doctor soldiers. They will be printed in our news letter and we can express our friendship by letters and cards to their wives who must carry on at home.

We do not know what the future may bring but we do know that we will all be deeply involved in the common cause of defense. We must be extremely careful that in our zeal and enthusiasm we do not plunge into some phase of defense work without first securing the approval of the advisory board. Every auxiliary, according to our constitution and by-laws must have its own advisory committee from its local medical society. We must depend entirely on their recommendations. Propaganda can so easily lead us astray.

At our national board meeting in Chicago we were urged to take an active part in health programs for defense. All health programs should be handled and headed by medical men; then only can we know that health statistics are authentic.

Dr. Nathan Van Etten, retiring President of the American Medical Association made this statement at Cleveland last June: "The progress which your organization has made during the last two years toward effective strength is most impressive." May our Kansas Auxiliary, during these trying weeks and months continue to develop strength and effectiveness.

As we enter into this new year of 1942, may I wish for you much more happiness than tragedies as we all work together to lay the foundation for better New Years in the future.

PRESIDENT'S INSTRUCTIONS

To the State Board—All reports must be sent to the State President not later than March 25. They must be typewritten, double spaced, in triple copies and on one side of the paper only. Study your hand books and make your reports accordingly. Give all information but leave out all unnecessary words. Remember that these will all be printed or mimeographed for distribution at our state meeting in Wichita.

To the officers—Beginning on page nine of the 1940 hand book, read again the duties of your respective offices. From these outlines make out your reports, giving statistics

of your accomplishments. Each auxiliary member should have a comprehensive knowledge of the work of the organization and it should be obtained from your reports.

To the state chairmen and chairmen of standing committees—If you have studied your hand book, you have already sent out an outline on which the local chairman must base their reports to you. You should be ready to send in your reports by March 25. Study the suggested outlines for chairmen in the hand book. Make them pertinent to our State.

To auxiliary presidents—1. Your 1942-43 dues were due December 15. If they have not been sent in to the State Secretary, send them immediately. Send with them two copies of the roster of paid members. These must correspond to the amount of dues.

2. Send in a separate list of members whose husbands are in service and who do not feel that they can pay dues.

3. Announce committee chairmen as soon as possible after election; then send in names of chairmen as soon as appointed.

4. Send in to the State Secretary two lists of the names of new officers immediately after election.

5. Explain duties to new chairmen in detail personally.

6. Contact the advisory committee of your county medical society before undertaking any local project.

7. See that the committee chairmen send reports to the State chairmen promptly.

8. Subscribe to the National Bulletin.

9. Answer all letters promptly.

10. Send publicity of programs: interesting data of all members of your auxiliary family to the State Chairmen of Publicity.

AUXILIARY NEWS

The Saline County Auxiliary met on December 11 at the home of Mrs. J. K. Harvey in Salina. Hostesses assisting Mrs. Harvey with the dinner were: Mrs. L. F. Eaton, Mrs. Herlan Loyd, and Mrs. John C. Mitchell.

The Women's Auxiliary to the Sedgwick County Medical Society entertained with a luncheon on December 8 in Wichita. Mrs. N. L. Rainey was hostess and Mrs. F. L. Menehan was in charge of the program. Mrs. J. W. Shaw reviewed the book "The Good Shepherd". Mrs. W. Y. Herrick of Wakeeney and Mrs. Herbert Atkins of Pratt were guests at the meeting. At a board meeting followed the luncheon Mrs. Herrick discussed plans for the 1942 State Auxiliary meeting in Wichita.

The Shawnee County Auxiliary met in Topeka on January 12 for luncheon. Dr. E. D. Greenwood of the Menninger Clinic spoke on "The Therapy of the Dance".

The wives of the members of the Southeast Kansas Medical Society were guests of the society at a dinner held in Fredonia on September 6.

The Wilson County Auxiliary entertained with a luncheon on December 11 in Neodesha. Mrs. W. Y. Herrick of Wakeeney, State President of the Auxiliary, was a guest and presented a report on the National Auxiliary Board meeting held in Chicago in November. Mrs. T. D. Blasdel of Parsons reported on the State organization work. Announcement was made that the county auxiliary had contributed tray sets for use in the Wilson County Hospital.

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THE TECHNIC OF A SIMPLE AND EFFECTIVE HEMOR- RHOIDECTOMY*

Louis J. Hirschman, M.D.

Detroit, Michigan

Internal hemorrhoids are vascular venous tumors, usually varicose, and covered with mucous membrane. The usual site for their occurrence is at the lower portion of the rectal ampulla where it merges into the anal canal.

Internal hemorrhoids are one of the most common diseases affecting humanity. At least one-seventh of the adult population have more or less hemorrhoidal trouble. Many patients who suffer from internal hemorrhoids, are also afflicted with external or cutaneous hemorrhoids. The latter, however, do not offer any serious problem in their treatment and are mentioned merely only incidentally to the discussion of the main topic.

Internal hemorrhoids occur most frequently in three constant locations. The three main groups occurring as follows: left lateral, right anterior, and right posterior. Secondary or smaller hemorrhoids may occur between the three primary groups. Occasionally, a primary hemorrhoid may be bifurcated.

The treatment of internal hemorrhoids is either palliative or curative. The various methods of chemical, thermic, or electric fibroization of internal hemorrhoids, are all examples of the palliative treatment.

Curative treatment is accomplished only by the surgical removal of the pathological elements which go to form those vascular tumors occurring beneath the mucous membrane of the rectum and known as internal hemorrhoids.

Many surgeons, and not a few proctologists, have divergent views as to the various principles entering into the successful removal of these tumors. It is surprising how many different methods have been tried and have been found wanting in the surgical treatment of internal hemorrhoids.

With the progress of time, and the improvement

of our knowledge of the principles involved in the operative relief and postoperative care of these patients, a gradual evolution has taken place.

It is my purpose, today, to bring you, by means of illustrative slides and of colored moving picture films, a technic for the successful removal of internal hemorrhoids, which is the result of many years of study in the special care of patients suffering from disease of the anus, rectum, and colon. This technic, as will be noted, has been simplified to a very marked degree as compared with complicated operative procedures now thrown into the discard. One can not consider that internal hemorrhoids are tumors which obstruct and impede a most important organ of elimination, without being struck by the fact that any operative procedure must not only dispose of the obstructive factors, but must also insure the normal patency of this important excretory outlet.

In our practice and in our teaching, we have laid down certain principles to be followed. That these principles are sound and conservative is proved by the happy results in thousands of our own patients and many others who have been successfully treated by that large group of men who are following these principles.

The surgical removal of internal and external hemorrhoids under some form of non-sleeping anesthesia has now become an accepted form of practice. The average patient demands surgery under such anesthesia almost as a routine. It is no longer necessary to stress the advantages of local, caudal, or spinal anesthesia for surgery of the ano-rectal region. The safety, convenience, and peculiar adaptability of these forms of anesthesia for the surgical treatment of ano-rectal diseases is today an accepted fact.

No longer is it necessary for the proctologist or the surgeon to struggle with a patient not thoroughly anesthetized on account of the timidity of the anesthetist, or to be in a constant state of apprehension on account of the inexperience of the occasional anesthetizer. The complete relaxation obtained through the employment of local or caudal anesthesia, particularly when administered by one of skilled experience, provides an infinitely better prepared operative field than can be obtained under any form of general anesthesia. This last statement

*Presented at the 82nd Annual Session of The Kansas Medical Society, Topeka, May 15, 1941.

might be modified only if infiltration is used to supplement general anesthesia in producing local relaxation impossible otherwise.

The employment of regional anesthesia for all operations in the anorectal region, below the recto-sigmoid, obviates the necessity of divulsion either manual or by the use of the bivalve speculum. The relaxation of the muscles of this region is complete and is accomplished without the trauma, caused in practically all of the patients when manual or instrumental divulsion is performed under general anesthesia.

While many anesthetic drugs are used for the production of local anesthesia, metycaine and novocaine stand at the head of the list. Either may be supplemented, however, by other anesthetic agents when one wishes to secure prolonged postoperative anesthesia.

For preliminary anesthesia, a one-half to one per cent solution of Novocaine, or half this strength of Metycaine, is satisfactory. A twenty c.c. glass syringe fitted with a flexible rustless steel needle one and one-half to three inches long, and of twenty to twenty-four gauge, is employed. The sharper the point of the needle, the more painless the puncture.

For the preliminary sphincter block, the one per cent solution of Novocaine, or one-half per cent of Metycaine is used. A point one-half inch posterior to the posterior commissure of the anus is selected. A quick thrust, at a right angle to the skin surface, is made instead of in the oblique direction. This makes the puncture painless, and, immediately after puncturing, considerable traction is made on the syringe piston to be sure a vein has not been punctured. The needle is then directed in a V-shaped direction, first on one side and then on the other, until the circumanal integument is slightly distended. This injection is subcutaneous and never intradermal.

Injections into the skin itself account for those occasional cases of slough which are reported by some operators. Most cases of slough, however, are produced when epinephrin is added to the solution. This drug is never added to anesthetic solutions in personal practice.

After skin anesthesia, the needle is inserted behind the sphincter and in the post-ano-rectal space on either side for a distance of one and one-half inches. From five to ten c.c.'s of the solution is used. If the operation is not to be prolonged, the one-half per cent Novocaine, or even one-four per cent Metycaine, solution is strong enough for the subcutaneous injection.

In two or three minutes complete relaxation of the anal sphincter occurs. An added injection under each hemorrhoid is advantageous, this should extend

up to, and beyond, the juncture of the pedicle and normal mucosa. All external hemorrhoidal tags or hypertrophied folds should be distended with the solution. This type of anesthesia, in the hands of a skilled operator, will suffice for all external hemorrhoids and for the majority of cases of internal as well.

CAUDAL ANESTHESIA

This is applicable for all cases where infiltration anesthesia is employed, but can be used also for fistulas, abscesses, and prolapse, in fact, for any pathology lying below the recto-sigmoid. It has the advantage over infiltration anesthesia in that one puncture is sufficient for complete anesthesia and relaxation in over ninety per cent of the patients. In the occasional case, where caudal anesthesia is not completely effective, it can be supplemented by infiltration.

Its technic is not difficult. The patient is placed on the operating table in the same position and prepared the same as for infiltration anesthesia. Palpation from the sacro-coccygeal juncture upward will disclose two bony prominences—the sacral cornua—on either side of the median line. The finger tip drops into the triangular depression between these. Only in the extremely obese patients in this triangle difficult to locate.

From twenty to forty c.c. of a one per cent Metycaine or of two per cent Novocaine solution is required for the production of caudal anesthesia. The skin is punctured in the center of this triangle, and injection is immediately begun. The needle is pressed through the tissues until one meets the resistance of the membrane covering the sacral hiatus.

When this is punctured, the needle immediately enters a free cavity and is advanced to the hilt. Before injecting into the caudal canal, it is well to aspirate in order to be assured that one has not punctured a vein. The appearance of blood on aspiration would indicate this, and the position of the needle must immediately be changed until aspiration does not produce blood.

The injection then proceeds until piston pressure indicates that the canal is filled to distention. If, after injecting a maximum of forty-five c.c., the canal does not seem to be distended, additional sterile water can be injected to produce definite pressure. Failure to enter the canal accounts for inability to produce caudal anesthesia in many instances. If, on injection, a wheal is produced beyond the point where the injection has been made, the canal has not been entered. It is sometimes difficult even for skilled operators to enter the canal in the extremely obese.

If the patient complains of a cramping sensation

in the dependent leg, usually the left, one may be sure that good anesthesia will follow. It requires from seven and one-half to twenty minutes to produce complete relaxation and anesthesia. Skin anesthesia usually follows in three to five minutes after relaxation of the sphincter muscles is complete.

Sub-arachnoid, or so-called spinal, anesthesia is employed by many surgeons because of the very satisfactory and complete relaxation which is secured. Fifty milligrams of Novocaine crystals dissolved in spinal fluid will usually produce sufficient exposure to perform a hemorrhoidectomy very satisfactorily. One objection to the employment of a spinal anesthesia is, that, in cases which are complicated or where the operation is unduly prolonged, the anesthesia will subside before the operation is completed.

OPERATIVE TECHNIC

The circumanal skin at, or just inside of its merge with mucous membrane, is grasped with triangular forceps and traction made at "twelve, three, six, and nine o'clock", this traction is maintained by 250 gramme weights attached to the anterior and left lateral forcep, and weight and chain to the right lateral forcep. The posterior one is maintained in position by attaching it to the canvas cover with a clip or Allis forcep. While in a great majority of cases there are three principal hemorrhoidal masses located respectively in the right anterior, right posterior, and left lateral areas, one or more secondary hemorrhoids may also be present.

Each hemorrhoid is grasped in turn with the hemorrhoidal forcep, and a blunt pointed ligature carrier threaded with number one chromic catgut is inserted just above the juncture of the hemorrhoid with normal mucosa deep enough to encircle its blood vessels. The ligature is firmly tied and the same procedure carried out with the other hemorrhoidal tumors. These ligatures which are mostly sub-mucous, while the knots are tied on the mucous surface, render the operation almost bloodless. The principle of tying before cutting is employed.

Starting with the most dependent hemorrhoid, it is grasped in the same manner as when the ligature was placed. Cutting from within, outward, in order to avoid undercutting the ligature, an ellipse of mucous membrane comprising not over one-third of the presenting hemorrhoid is excised.

It is quite proper, after making the first cut from within outward, to complete the excision in the opposite direction. The edges of the mucosal wound are lifted up with forceps and all varicose veins destroyed underneath the membrane and removed by severing them. Each hemorrhoid is treated in like manner. The sphincter or its sheath should be exposed in each wound, this prevents injury to this

important muscle, and also insures the removal of all of the varicose veins which compose the hemorrhoid.

The hemorrhoid itself is a tumor composed mainly of diseased veins. Inasmuch as the removal and destruction of the bowel lining by cautery results in cicatricial contraction with deformity and distortion, such a procedure can not be classed as good, conservative surgery. On account of this unnecessary sacrifice of mucous membrane, any form of clamp is contraindicated because all of the tissue, whether healthy or diseased, which is included in the bite of the clamp, must be entirely removed instrumentally or by the use of the cautery. It is very rare that a clamp can be put sufficiently far down to the base of the hemorrhoid to include all the pathology without catching up some of the sphincter fibers. A clamp operation, therefore, is necessarily a blind or incomplete operation.

It is quite as illogical to clamp and cut away the mucous membrane covering a vascular tumor, which we know as an internal hemorrhoid, as it would be to use the same technic and cut away the skin covering any vascular tumor of the arm or leg. It is well to examine for bleeding points and ligate any spurting vessels. If the original ligatures have been properly placed, there will be very little of this bleeding.

An important principle to be observed in the surgery of this region, is to abstain from the suturing of all wounds in the mucous membrane of this cavity, whenever possible. In spite of our best efforts and advanced methods of aseptic preparation, it is well known that it is impossible to secure a surgically sterile field.

During the course of an operation, the mucous which is constantly secreted comes in contact with the wound and bathes it with bacterially infected material. If one attempts to close a wound in this region by suture, this infective material is enclosed, drainage prevented and suppuration inevitable.

This brings up another principle, that of drainage in anorectal surgery. Every wound made in the anorectal canal must be carried down through the anal aperture to the perianal skin. All external hemorrhoids, as well as hypertrophied folds must be excised. All incisions must be made radial to the orifice and paralleling the radiating skin folds.

No cups or pockets must be left at the outer extremity of any of these incisions. Every skin wound must taper to a point, so that the edges will agglutinate and heal practically by first intention if made properly and not sutured. The purse-string action of the external sphincter and the corrugator cutis ani muscle will tend to draw the wound edges together, so that suturing, while absolutely inadvisable, is seen to be also entirely unnecessary.

In order to secure good postoperative anesthesia, about ten c.c. of a .5 per cent solution of either quinine urea hydrochloride or diethan hydrochloride is injected underneath the skin completely surrounding the anus. This injection is made under, and not into, the integument. One or two c.c. should be injected into each postero-lateral quadrant to anesthetize the sphincter. A strip of soft rubber tissue covered with some analgesic ointment is inserted. The formula of the one used in our practice is as follows:

Rx Benzocaine	4 gms.
Chloretone	4 gms.
Thymol Iodine	4 gms.
Emollientine (to make)	120 gms.

Dispense in nozzled tube. Use freely.

Another very important principle to be observed is the abstinence from that almost irresistible impulse to insert a tube, a pack or a tampon into the rectum after an operation. The surgeon is tempted to do this to control hemorrhage, to provide drainage, or to keep the rectum and its muscles "in extension" during part of the healing process.

If one is following the principle mentioned above, viz: to ligate before cutting, any sort of pack to control hemorrhage will be entirely unnecessary. If packing and tubes are inserted to provide drainage, this is only necessary if you can not relax the sphincter under some sort of regional anesthesia, but the tube or pack acts as a foreign body and induces earlier peristalsis than is desired by either patient or physician. One secures such perfect relaxation through the employment of sacral or spinal anesthesia, that the muscles relax to an extent unbelievable until it has been actually observed by the surgeon.

As soon as sensation returns to the parts, any material inserted into the rectum by the surgeon produces the same peristaltic stimulus as a stool would do, and evacuation with an unnecessary and inexcusable amount of pain and suffering is thus produced. This has been proven by us and by others in the employment of rectal tampons or pneumatic dilation of rubber bags inserted into the rectum, to induce peristalsis in the treatment of chronic atonic constipation.

If you wish to provide drainage and prevent agglutination of opposing raw surfaces, a strip of rubber dam or gutta-perche tissue not over one inch in width may be inserted into the anal canal and will remain without the patient being conscious of its presence.

Another principle to be observed is the avoidance of prescribing any such drugs as opium, bismuth or salol, or any of the various astringent proprietary preparations on the market to "lock up the bowels." If there is one thing the bowels will not do after a

rectal operation, provided that peristalsis is not stimulated by the presence of foreign material, such as gauze, it is to move without assistance.

As a matter of fact, in our practice, it is the custom to administer large doses of mineral oil on the evening following the operation, and every evening thereafter, in order to facilitate the bowel movements when it is desirable to start the same.

When one realizes how many ounces of bismuth have been administered in the preparation of the gastro-intestinal patient for an x-ray examination, one realizes then how futile it is to administer a few grains of this drug at frequent intervals to impede or prevent bowel movements.

The administration of mineral oil is of chief value as a lubricant to facilitate the passage of the stools. In this postoperative use, it does render this contact with raw surfaces less irritating. Best results, however, in the administration of mineral oil are achieved by the employment of one large dose at bedtime.

Only too frequently the oil is mistakenly taken before meals as well as at night. If an inert and indigestible oil is administered just before food is taken, it is quite certain that food particles will be coated with an impervious film of oil and digestion prevented. That this does occur is evidenced by the fact that so many patients object to mineral oil, because digestion is disturbed, and they suffer from eructations of gas after they have taken the oil.

Interrogation of these patients reveals one fact: that it is only when oil is administered before meals, that they are disturbed by the formation of gas. Patients who take oil at bedtime do not make this complaint.

For those patients who can not take mineral oil or where it is felt that mineral oil might interfere with the absorption of the fat soluble vitamins A, D, E, and K, we substitute one of the non-irritating water-carrying bulk lubricants. Among these may be mentioned: Siblin, Mucilose, Mata-mucil, Kaba, Bassoran, Karaga, and similar materials. These are usually administered dry, in teaspoonful doses, after each meal, followed by at least a full glass of water. These preparations have the advantage of providing a formed, soft, residue-free, lubricated, stool.

A well-formed stool is nature's dilator, and as it acts from within outward during defecation, the sphincter is dilated in the normal physiological direction and manner.

In the after-care of patients following hemorrhoidectomies, the use of heat, either dry or moist, contributes materially to their postoperative comfort. Hot compresses covered with hot water bags can be used as much as the patient desires. Hot sitz baths, especially following defecation, are of great

value and much appreciated. Most patients who have received postoperative injections of quinine urea or diothane solutions seldom require narcotics or other sedatives. Catheterization is the rare exception and is required only in patients who have some prostatic pathology.

Patients are allowed to be up and out of bed on the second day and to have bathroom privileges as soon as they wish. The average hospitalization following most hemorrhoidectomies is from four to seven days.

In conclusion: it may be stated that the rationale of internal hemorrhoidectomy is based on the proper diagnosis, adequate preoperative preparation, satisfactory anesthesia, relaxation instead of divulsion of the sphincter muscles, exposure without the use of speculums or retractors, removal of the varicose tumors called hemorrhoids without the sacrifice of their mucous membrane covering with preliminary hemostasis, adequate drainage by means of tapering radial external incisions, postoperative anesthesia by the use of quinine urea, diothane, or anesthetic oil injections, simple rubber dam drainage without tubes or packs, the use of lubricants instead of cathartics for postoperative defecation, the employment of heat to assist in postoperative comfort, and a minimum confinement to bed and to the hospital.

The early restoration of the parts to normal appearance and function is the best evidence of the soundness of the principles here enunciated and their practical value, as has been evolved from a long and varied experience in the treatment of proctologic patients.

What they believe is the first reported case of inflammation of the marrow (osteomyelitis) of the head of the thigh bone due to *Bacterium necrophorum*, an organism which has been found to be the causative agent of such conditions as infection of the blood stream, abscesses of the liver and lungs and inflammations of the joints, is described in *The Journal of the American Medical Association* for May 24 by Fremont A. Chandler, M.D., and Virginia M. Breaks, A.B., Chicago.

The case reported was that of a boy aged twelve years who was admitted to the hospital with draining of the left ear of two weeks' duration and pain in the right hip of three days' duration. The boy eventually recovered. In commenting on the case the two authors say "The ability of *Bact. necrophorum* in pure culture to invade tissue and to become localized is strikingly demonstrated in the case described. . . . It seems probable in this case that the middle ear was the primary focus (of infection). . . .

"The increased number of infections due to *Bact. necrophorum* reported in the literature and their seriousness of fatal outcome makes their recognition worthy of more consideration. . . . Although this is apparently the first case of its kind reported in the literature, it is probable that this disease process would be found more often if similar studies were made."

THE MANAGEMENT OF EARLY TOXEMIAS OF PREGNANCY

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Many articles have been written about the treatment of the late toxemias of pregnancy and convulsions. However, there is very little in the literature about the treatment of the early and milder forms. A review of the treatment of the early cases should be of more interest to the physician practicing obstetrics because all his severe cases were at some time in the early stages of the condition and should have been treated at that time. There are some changes in the management of the toxic pregnant woman of the present day compared to the routine procedure ten years ago. It is the purpose of this paper to stress what can be done for the toxic pregnant woman by dietary regulation and by sedation if instituted at an early stage. This type of treatment assumes that the patient is getting frequent and careful prenatal examinations. Any physician who gives his patients the best in modern prenatal care is doing no more than his professional duty. However, it is only by keeping his patient under constant supervision that he can help her, and at the same time have the satisfaction of having done his work well.

We apply the term toxemia of pregnancy to a certain group of signs and symptoms varying from a generalized feeling of discomfort and irritability to the extreme condition progressing into convulsions and finally death. It is assumed that the body contains poisons or toxins but they have not been demonstrated. We do know, however, that there must be some deficient or abnormal metabolism which disturbs the function of the liver, kidneys, nervous system, and capillary walls. This imbalance is partially chemical, as can be demonstrated by a change in the body electrolytes, but it is no doubt also of an endocrine nature due to liberation of substances from the fetus and placenta.

The symptomatology of toxemia includes headache, dizziness, hyperexcitability, muscle cramps, neuritis, skin eruptions, nausea, vomiting, palpitation, syncope, colic, constipation, etc. on up to the graver symptoms of water retention, oliguria and convulsions.

The time to begin the management of the toxemic patient is at the very first sign of trouble. Every physician has a brief mental outline of how he proceeds with his toxic patient. In this paper we wish

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to present an outline of therapy which has not only kept our pregnant women in health, but has also kept the majority of them feeling very comfortable. We also wish to point out the rationale of why these procedures should work as they do.

As a basis for reasoning out a treatment for early toxemia we are simply following the basic principles of treating a severe toxemia. The most accepted methods in treating eclampsia are morphine, the barbiturates, chloral hydrate, magnesium sulfate and hypertonic glucose. Summing it up we have sedatives on the one hand in morphine, the barbiturates and chloral hydrate; and on the other hand we have magnesium sulfate and glucose to help reduce body fluids.

Nearly everyone will agree that the toxic patient is a nervous patient regardless of whether any organic pathology is present or not. In my opinion the nervousness and the symptoms related to the nervous system such as headache, aching in legs, uncomfortable feeling in abdomen and back are the first indications of trouble. One should not wait for the conventional signs of trouble such as weight gain of over one pound a week, systolic pressure over one hundred forty and diastolic over ninety, albuminuria and edema. These things will soon follow if the nervous system symptoms go untreated. Nervousness and sleeplessness can alter the function of the kidneys and blood vessels and thus hastens on an impending toxemia.

In treating the early toxemia one should first of all see that the patient has an adequate diet. This should include a quart of milk a day, one serving of lean meat, liberal amounts of fruits and vegetables, and in some cases vitamins need to be added.

Milk is important for two reasons: first its calcium content, and second as a source of animal protein. Calcium is necessary for the maternal and fetal metabolism. A calcium deficiency is partly responsible for the aching and neuritis symptoms because the sensory nerves become hypersensitive and irritable with a calcium deficit. If the patient is unable to drink milk, some form of calcium therapy should be prescribed for her. Along with the proper calcium intake, some vitamin D should be added especially during the winter months, as this vitamin is essential for the utilization of the calcium.

In the past there has been some controversy about giving a pregnant woman meat and until a few years ago the tendency was to omit meat, eggs and fish. Strauss studying the effect of a high protein diet on toxic patients, in 1936, came to the conclusion that there was clinical improvement with a drop in blood pressure and decrease in albuminuria when more protein was used. The blood plasma albumin is already decreased in a pregnant woman

as compared with the non-pregnant woman. The toxic pregnant woman has an additional significant decrease in plasma albumin and an increase in plasma globulin. This decrease in plasma albumin tends to favor water retention and edema due to an osmotic difference in the plasma and interstitial fluid. Albuminuria further depletes the plasma and the edema continues to become more acute. With this point of view in mind it is not only permissible, but it is absolutely essential to have some meat in the diet. Animal proteins are the only source from which the plasma albumin can be replaced. The national committee of food and nutrition recommends eighty-five gm. protein for the pregnant woman.

A liberal amount of fruits and vegetables makes a good source of vitamins and minerals. These will do much to keep up the general health of the patient. If neuritis is present some vitamin B should be added. The suitable vitamins can now be included in one or two capsules a day. The high calory foods such as potatoes, pastries and sweets should be discouraged. It is a poor policy to allow a patient to put on fat. Some of this fat is deposited on the inside of the pelvis, so the fat woman is deprived of some pelvic space by this extra soft tissue.

If the pregnant woman is getting the proper diet and still has her nervous system symptoms the treatment of choice is bromides. The majority of patients respond excellently to this type of sedation. Sedation is the most essential part of the treatment of advanced toxemias, so it would be wise to treat the mild cases in this manner. Bromides have several advantages over the barbituric acid preparations for the ambulant patient. First of all it does not dull the patient mentally and secondly it does not give them that sleepy feeling which in turn makes them think they are tired and weak. Bromides relieve the hyperirritability of the sensory nerves and thus does away with a great many aches and pains. It relieves the nervousness which in turn lowers the blood pressure ten to twenty m.m. It gives the patient a chance to sleep and rest, in this way building up her health instead of tearing it down by sleepless nights, nervousness and aching. Bromides should be given as the potassium salt or as the five bromide combination to the toxic pregnant patient. A dosage of $\frac{3}{4}$ teaspoonful of a syrup or elixir, taken before meals and at bedtime, will give the desired results and at the same time does not cause bromism; this gives the patient forty to forty-five grains a day. Sodium bromide is contraindicated due to the sodium ion as will be pointed out later. The five bromides contain sodium, potassium, ammonium, calcium and lithium ions, so the proportion of sodium is small in this preparation.

There are of course a number of cases where the toxemia will progress in spite of sedation and an adequate diet. This progress will be indicated by excessive weight gain, edema of feet and hands, albuminuria and some elevation of blood pressure. These patients should be placed on the following treatment: fruit juices and milk diet two days out of a week; removal of excess salt from diet; and small doses of magnesium sulfate each morning. All these are directed at balancing the electrolytes in the body, maintaining a proper acid base balance and at the same time removing the excess body fluids.

With the addition of the fetal exertion the toxic patient retains both urinary waste and electrolytes in the blood plasma and the plasma becomes hypertonic. Most of the body fluids are in the following form; plasma in the circulation, interstitial fluid which surround the cells and fluid in the cells themselves. As the plasma becomes hypertonic some small molecules and inorganic ions pass into the interstitial spaces seeking to maintain an osmotic equilibrium. This hypertonic condition in the interstitial spaces in turn draws water out of the cells. The edema then is in the interstitial spaces and the body cells become dehydrated. In treating edema and the related toxic evidences an electrolytic balance must be maintained by proper diet and regulation of salt.

Attention must be given to the acid base balance. Milk, fruits and vegetables produce a basic plasma. An excess basic plasma favors edema. Meat produces an acid plasma. An excess acid plasma causes just as severe a toxemia but with less edema. Serious toxic developments occur with a departure in either direction from a normal acid base balance.

A diet of fruit juices and milk two or at most three days out of a week keeps up the basic requirements of the body. An ordinary pregnancy diet containing some lean meat keeps up the acid requirements making somewhere near a neutral ash. One suggestion in a diet of milk and fruit juices is to take fruit juices the first half of the day and milk the last half rather than mix the two throughout the day. Some patients' stomachs do not tolerate a mixture of milk and fruit juices in close succession. A diet of milk alone, as was formerly advocated, causes a basic plasma which would actually hasten the formation of edema and precipitate a convulsion.

All excess salt in the diet should be eliminated on account of the sodium ion. Sodium enters into the interstitial spaces and helps form edema while the potassium ion tends to displace it. The chloride ion is not active in the storage of fluid. Therefore sodium chloride should be limited as much as possible. This is also the reason for using some other bromide

than the sodium salt. All seasoning should be at a minimum. Two days of fruit juices and milk also help limit the total sodium chloride intake for the week.

The action of magnesium sulfate is not known, however, we do know that it helps remove the interstitial fluid. The sulfate ion also has a buffer action on the plasma. The amount taken should be just enough to produce one bowel movement. It should be taken regularly every morning on an empty stomach, the dosage ranging from one-half teaspoonful on up according to the requirements of each patient. It should not be taken in large enough doses to be a cathartic unless one is ready for the patient to go into labor. A small amount taken regularly does not hasten the onset of labor.

SUMMARY

In the management of the early toxemia of pregnancy the emphasis cannot be placed too strongly on frequent and careful prenatal examinations. Properly regulated diet of one quart milk, one serving meat, plenty fruits and vegetables with some added vitamins will keep many patients below the toxic threshold. Nervousness, neuritis and generalized feeling of discomfort are the first signs of warning. Excess weight gain, albuminuria and edema are late signs. These nervous system symptoms are very successfully controlled and the patient reports a feeling of well-being by taking bromides in the form of the potassium salt or the five bromide combination. A toxic patient up to this early stage begins improving if nervousness is controlled.

For advancing signs of toxemia the patient should have a limited salt intake, a diet of fruit juices and milk two days out of a week and small doses of magnesium sulfate each morning. These procedures help balance the electrolytes in the body and maintain a proper acid base balance, a disturbance of which accounts for many of the signs of toxemia. The physiological basis for the above has been described in this paper. With these findings in view, some of the concepts of treatment, of not so many years back, need to be revised.

The point of greatest importance is that many patients who are toxic in the late months of pregnancy are normal in the early months of pregnancy. By proper diet and by sedation a large per cent of this group can be carried through an entirely uneventful pregnancy. Success rests in being on the look-out for the first sign of warning and to begin treatment at once.

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SURGICAL PATHOLOGY OF TOXIC AND NON-TOXIC GOITER*

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The surgeon who requests a histologic examination of a removed goiter, is less interested in a detailed anatomic description of the specimen than in an opinion on its functional value. He wants to know whether the goiter is toxic or non-toxic.

What then are the possibilities, what the limitations of our present methods in making a histophysiologic diagnosis of thyroids. The pathologist who attempts to correlate the structure and the function of the diseased thyroid should familiarize himself first with the histophysiology of the normal gland. Studies of the normal thyroid in man and in animals form the scientific basis for evaluating the activity of the thyroid by microscopic examination. From the recent work of cytologists, physiologists, and experimental pathologists, the following conclusions seem justified.

THE COLLOID

The colloid represents the anatomic substratum of the active secretion of the thyroid. The activity of the thyroid is cyclic. The first phase consists of the production and intrafollicular storage of colloid. The second phase is characterized by resorption of colloid into the capillaries. Cuboid cells are linked to colloid secretion, while columnar epithelium has the function of resorption. Cells of different height and therefore of different functional value may be found not only in different follicles of the same gland but even in the same follicle.

The colloid release can be precipitated by an injection of extract of the anterior lobe of the pituitary containing the thyrotropic factor. During colloid resorption the intrafollicular colloid is transformed into a thinner, more soluble state. For normal as well as for increased function of the thyroid the maintenance of the cyclic mechanism of colloid storage and colloid release is indispensable. Preponderance of colloid release over colloid production leads necessarily to exhaustion of the gland.

In the light of these fundamental principles of

the normal physiology of the thyroid it is apparent that the activity of a given goiter specimen cannot be judged from the colloid content alone. Some writers assume that the colloid is produced continuously and always at the same rate; they interpret scarcity of colloid as anatomic evidence of increased resorption and of hyperfunction, abundance of colloid as evidence of sluggish resorption and decreased thyroid activity. These pathologists overlook the fact that the amount of colloid in a gland depends first of all on the rate of secretion which has never been proved to be constant. There are goiter forms, for instance fetal adenoma and lymphadenoid goiter, which are very poor in colloid and are associated with definite symptoms of low thyroid function. On the other hand, the diffuse colloid goiter with its abundance of colloid, is in adults often associated with hyperthyroidism. Therefore the histologic picture of colloid storage is not identical with low thyroid activity.

While most goiter students accept only one chemical form of colloid, some assume a non-toxic and a toxic variety. Plummer's distinction between exophthalmic goiter and toxic nodular goiter as different clinical and pathologic entities is based on the theory that in the first a toxic hormone is produced, in the second an excessive amount of normal thyroxine. There is no morphologic and no chemical finding to support Plummer's view. Troell expressed the opinion that thyrotoxicosis whether from exophthalmic goiter or from toxic nodular goiter is characterized by a specific toxic colloid. The latter stains, according to him, blue with Mallory's method, while non-toxic colloid stains red. After employing different stains in a large number of normal as well as diseased thyroids, I am convinced that there is no differential stain for normal and toxic colloid. The blue color with Mallory's aniline blue indicates not a chemical alteration of the colloid but only a higher dispersion. The thin colloid in exophthalmic goiter stains exactly like the colloid in normal thyroids of infants.

THE EPITHELIUM

The size and shape of the thyroid cells are a more reliable criterion of thyroid activity. Goormaghtigh and Thomas expressed the opinion that by counting the segments of columnar epithelium and by measuring their extent it is possible to determine almost mathematically the functional value of a given goiter specimen. The difficulty of depending entirely on these epithelial changes lies in the fact that they are not always present throughout the gland but often only in small areas. The focal nature of the epithelial proliferations makes it often necessary to examine many sections from different parts of a

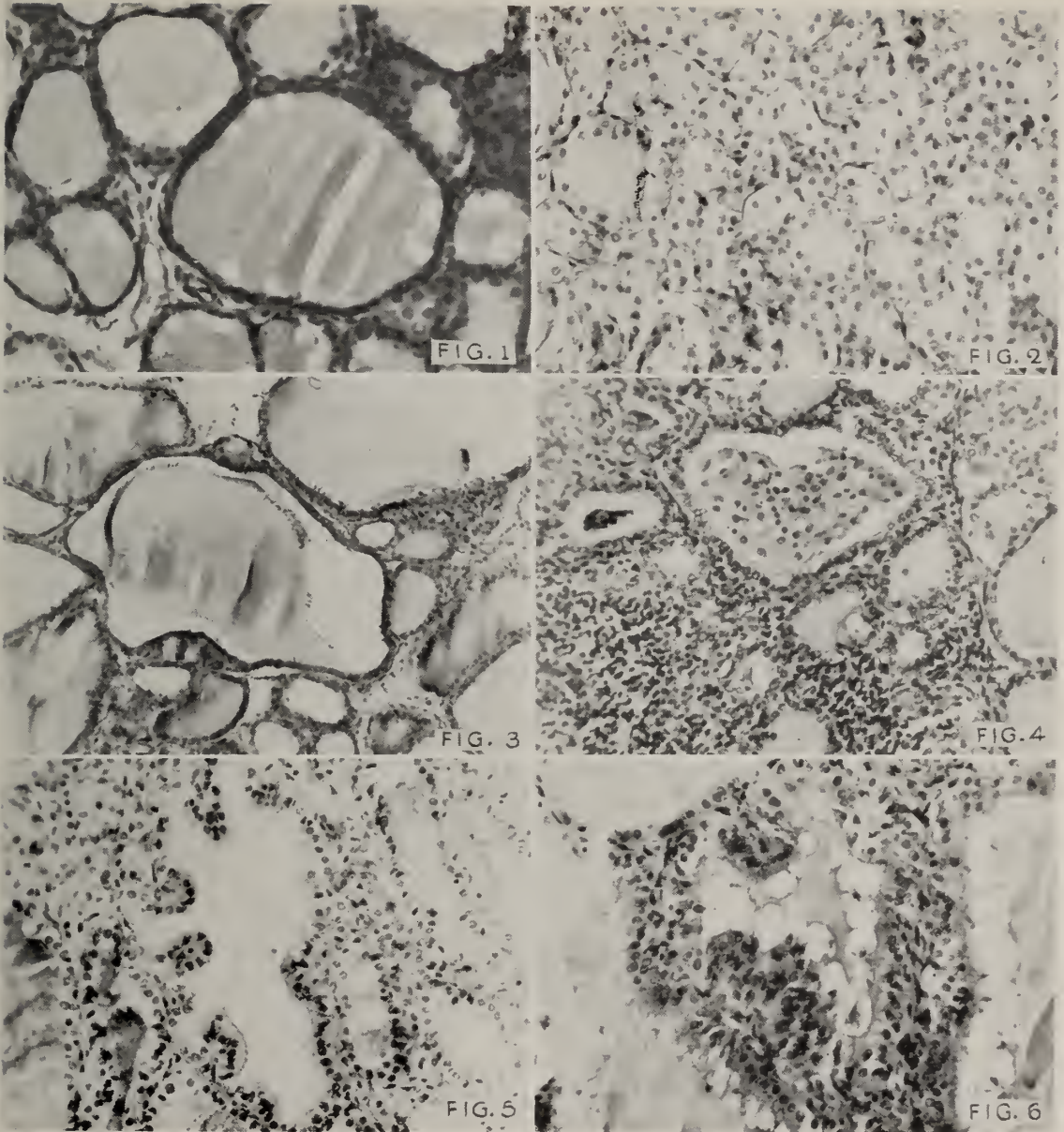


Fig. 1. Normal thyroid of rabbit. Secretory phase of cycle of thyroid function. The only known factor which produces this phase is iodine. Fig. 2. Normal thyroid of rabbit. Resorptive-proliferative phase of thyroid function. This phase can be produced in the experimental animal by administration of anterior lobe of the hypophysis. Fig. 3. Diffuse colloid goiter with definite hyperthyroidism in forty-seven year old female. This type of goiter is not an involution, but an exaggeration of the secretory phase of thyroid activity. Fig. 4. Lymphadenoid goiter in thirty-three year old female, with definite hypothyroidism. This type of goiter is not an inflammation, but an exaggeration of the resorptive phase of the thyroid function. Fig. 5. Papillary proliferation in diffuse goiter with liquefied colloid indicates in adults exophthalmic goiter. In children papillary proliferation may be associated with normal or decreased thyroid function. In adenomas the same structure is without functional significance, even in adults. Fig. 6. Exophthalmic goiter after Lugolization. Combination of secretory and resorptive-proliferative phase. In adults a histological picture of this type allows the clinical diagnosis of exophthalmic goiter.

gland. While papillary proliferation of columnar epithelium is found almost exclusively in exophthalmic goiter there are exceptions. Goiter in adolescents in regions of severe endemicity may have all the histologic characteristics of exophthalmic goiter and still be associated with normal or low thyroid function. In adults, columnar epithelium may be present

in benign and malignant adenomas without being associated with toxic symptoms.

Hertzler believes that papillary proliferation always indicates exophthalmos in the patient, and that solid hyperplasia indicates absence of eye signs. I find it impossible to diagnose the presence or absence of eye signs from the microscopic slide. The

so-called solid form of exophthalmic goiter without papillae is not a special type but the end stage in the epithelial proliferation of exophthalmic goiter. Not infrequently, does one find papillary and solid proliferation in the same microscopic field.

The study of the finer intracellular structures with consideration of mitochondria, intracellular vacuoles, lipoid granules, and Golgi apparatus reveals only quantitative differences between toxic and non-toxic goiter. As far as the microscopist is concerned, the only disturbance which can be demonstrated in toxic goiter is epithelial proliferation associated with liquefied colloid. Not only morphologic methods, but also chemical and biologic studies fail to reveal an abnormal chemical constitution of the secretion in toxic goiter. All toxic goiters, from the monosymptomatic, cardiotoxic form to the severest type of exophthalmic goiter are apparently variations of a single disease caused by excessive production of normal thyroxine.

DIFFUSE COLLOID GOITER

Few physicians seem to realize that the great majority of surgical goiters develop in this structure. The diffuse colloid goiter is in my opinion the key to the goiter problem in our country.

In Marine's opinion, colloid goiter never does develop from a normal thyroid, but is an involution of hyperplastic goiter. From my own studies of surgical and autopsy material, I believe on the contrary, that the colloid goiter develops directly from the normal gland and is not preceded by the cellular, colloid-poor parenchymatous goiter. While the diffuse colloid goiter is characterized by an abundance of colloid, careful study will reveal, in glands of patients who did not receive iodine before operation, buds of epithelial proliferation in the wall of some follicles. Often these cushion-like elevations of the epithelial wall become more numerous and more elevated, until finally the typical picture of exophthalmic goiter is apparent.

In adolescence and during pregnancy this type of goiter is very common and, if small, almost physiological. In both periods of life, where the demand for thyroxine is increased, it expresses a successful attempt of the thyroid to produce more secretion. It certainly is not a sign of involution. I have never seen a true case of myxedema associated with diffuse colloid goiter, and as far as I know there has never been one authentic case reported. If the diffuse colloid goiter persists or develops after the twenty-fifth year, without a pregnancy being present, then definite symptoms of mild hyperthyroidism are evident in the majority of cases. In my own material, this type of goiter is associated in adults with signs of hyperactivity in eighty-one per cent of the cases.

EXOPHTHALMIC GOITER

The pathologist is justified in making a clinical diagnosis of exophthalmic goiter if he finds in the microscopic slide the following three structural changes:

1. Marked variation in size and form of the acini. Columnar epithelium with closely packed basal nuclei.

2. Decreased amount of colloid. The colloid is thin and often vacuolated. It takes eosin only lightly or not at all and stains blue with Mallory's aniline blue.

3. In about three-fourths of the cases groups of lymphocytes, often with distinct germinal centers are found.

The introduction of preoperative medication with iodine has changed the microscopic picture, producing an increase in well stained colloid. However, in the majority of treated cases, the characteristic hyperplastic changes of the epithelium are still present, so that a positive diagnosis can be made as well as in untreated cases, provided different sections from several tissue blocks are examined.

Exophthalmic goiter develops as a rule in diffuse colloid goiter, when the release of the abundant intrafollicular colloid becomes intensive. The manufacture of intrafollicular colloid has to remain at a high level; otherwise the whole gland would show exhaustion as one sees in lymphadenoid goiter. That in exophthalmic goiter the acinar cells have retained their ability to produce intrafollicular colloid, is demonstrated by the effect of iodine medication. Large colloid filled acini appear within ten days and the exophthalmic goiter is converted into a diffuse colloid goiter. Both types of goiter are closely related, and they may change easily one into the other.

LYMPHADENOID GOITER

In 1925 Williamson and Pearse described a type of goiter characterized by lymphocytic infiltration and ending in myxedema to which they gave the name "lymphadenoid goiter". The cause, histogenesis, and clinical significance of this thyroid disease are little understood. Most writers agree that the goiter described by Williamson and Pearse is the same which Hashimoto in 1912 designated as struma lymphomatosa.

The cut surface of these goiters is divided into lobules, and the structure is uniform throughout the gland. The tissue is white, firm, and hard. No nodules are visible. The microscopic picture is striking because of an abundance of lymphoid tissue. Not only is the lymphocytic infiltration diffuse within the lobules and in the septums, but many lymph follicles with large germinal centers are present in every specimen. The acini are mostly of small size and have

round, oval, or more often slit-like lumens. The lining epithelium is high cuboid and measures between eight to twelve mikrons. Stained colloid is extremely scanty and absent in most acini. Many lumens contain groups of cells which resemble giant cells or syncytium. Some of the acinar cells are swollen and of irregular form. Their granular protoplasm takes an intense stain with eosin, and the nuclei are also irregular in size and shape and stain deeply with hematoxylin.

In most cases the patient is a woman in the late forties inclined to obesity with a rather dry skin and with a basal metabolic rate which suggests a moderate type of myxedema. In none of our cases did the disease appear to have been engrafted on an established goiter-exophthalmic, colloid or nodular. I regard the lymphadenoid goiter as a distinct clinical and pathologic entity. It is not an inflammatory process, as some writers believe, but the result of a functional disorder. The cycle of colloid storage and release is fundamentally disturbed, the release of colloid being much more intense than the manufacture and storage. In this way the supply of colloid becomes exhausted and symptoms of hypothyroidism result.

SUMMARY

A functional diagnosis can be made from microscopic study in most cases of diffuse goiter.

Nodular goiter, on the other hand, presents so varied pictures that microscopic examination does not allow an opinion on its functional value.

There is no reliable differential stain for toxic or non-toxic colloid.

Toxic nodular goiter is a purely clinical, not anatomical, diagnosis.

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Two things to remember.

1. Semi-annual physical examinations if you are over thirty.
 2. There are over 36,000 living proofs that early cancer is curable.—Bulletin of the American Society for the Control of Cancer, Inc.
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According to a statistical bulletin of the Metropolitan Life Insurance Company, more persons die at age seventy-one in the United States than any other age, except in the first year of life. In 1939, the latest year for which data are available, there were 103,846 deaths of infants under one year of age and about 30,000 deaths of persons at age seventy-one.

PNEUMOPERITONEUM FOLLOWING A DOUCHE

Maurice A. Walker, M.D.

Kansas City, Kansas

A white woman, aged forty-three, mother of one child, had made it her custom to take a douche through a rubber tube attached directly to the mixing faucet on the bath tub. In the afternoon of October 14, 1941, she noticed that some bubbles of air came from the faucet while she filled the tub for a bath. She recalled subsequently that the water had been turned off earlier that day while mains were being repaired. After bathing she regulated the temperature of the water from the faucet and inserted the tube into her vagina while still lying in the bath tub. She felt a sudden explosive feeling in her vagina followed by the expulsion of bubbles of air. Her abdomen began to become distended and tight. This rapidly increased within the next few minutes until she became quite uncomfortable and short of breath.

When seen about thirty minutes later she complained of distention and of pain radiating to the right scapular region. Her abdomen was tense and tympanitic. Her pulse rate was 120 and blood pressure ninety-five systolic, seventy diastolic. Although she was obviously quite ill, she refused to go to a hospital. She vomited several times during the next few hours. Nausea and distention persisted for four days. Her abdomen gradually became softer. When examined on December 15, she stated that she had been perfectly well since ten days after the accident and had menstruated normally.

COMMENT

Without doubt this patient accidentally insufflated air into her peritoneal cavity, resulting in considerable discomfort for several days but without serious or permanent injury. One might speculate as to why she had not previously forced water through the uterus and tubes by this method of douching. This probably had not occurred because she used a slow stream which escaped easily from the vagina. On the occasion described it would seem that a volume of air which had been trapped and compressed in the water pipes entered her vagina. There, due to the sudden release of pressure, the air increased in volume more rapidly than it could escape from the vaginal orifice, some being forced through the uterus and tubes into the peritoneal cavity.

President's Page

To The Members of The Kansas Medical Society:

It is quite certain that all members agree that those responsible for our Journal are doing a wonderful job, the appearance has been greatly improved and the material published is of the highest order. Many comments have been noted from numerous society members praising the improved quality of each issue. All power to the Journal personnel for a real job being well done.

One cannot escape the observation of war activities in these days of stress that is reaching all individuals in one way or another. It is especially gratifying to note the increased response of the medical profession of the nation and our state. Kansas medicine is not lacking in her loyalty in this the greatest of all emergencies. Further demands will be made in the near future, let us as men of Kansas and representatives of the noblest profession in existence, respond freely to our country's call.

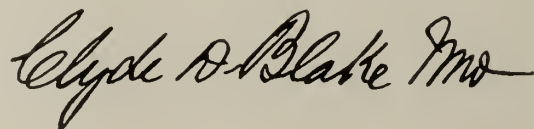
The various committees of our Society are continuously functioning. There is much of importance being constantly considered and the welfare of the Society as a whole is always uppermost in the minds of your officers and committee personnel.

Many problems of possible questionable import are in the offing and are being carefully considered in the various committees and will soon be considered by the Society Council.

Great advancement has been made in Kansas medicine in the past twenty years and much of great importance has occurred in the past decade.

Let us carefully weigh each course of action as a united body and by so doing bring about the greatest good to the general public, whom we serve, and in return we will reap a reward of high esteem and professional attainment.

Sincerely yours,

A handwritten signature in cursive script, reading "Clyde O. Blake M.D.", written in dark ink.

EDITORIAL

PROCUREMENT AND ASSIGNMENT

Several announcements have been made recently which indicate that much progress and intelligent planning have been made in regard to the procurement and assignment program for physicians. In fact, it would seem true that no more efficient and practicable plan could be devised than the one now contemplated by the Procurement and Assignment Service in Washington. The announcements referred to above are as follows: that all needs for physicians will be placed under the supervision of the Procurement and Assignment Service and that all military and other official agencies desiring physicians will obtain them from that source; that the Army and Navy will grant commissions in the Medical Corps only thru the recommendation and approval of the Procurement and Assignment Service; that the National Selective Service Headquarters has ruled that no physician will be conscripted at the present time unless such is approved by the procurement and assignment agency; that the Civil Service Commission and others interested in obtaining physicians will follow an identical procedure; and that civilian needs are to be protected to the fullest extent possible through certain other arrangements now being made.

The program is to be furthered thru the medium of a questionnaire which is to be issued in the near future, wherein all physicians in the country will be extended an opportunity to volunteer their services for the work they feel they can best perform. Likewise, lapel buttons are to be given to all physicians who execute and return the questionnaire forms, to show that their services have been volunteered.

Many advantages will undoubtedly result thru the placement of the entire medical procurement and assignment matter in a single agency and thru the possibilities made available thereby for correlating volunteered services with military and civilian needs. Under this program, physicians will need only to outline their training, types of practice, and the places in which they feel they can best serve and then to wait until the agency which needs their assistance makes a request for physicians in their general age group and circumstances. In the meantime the corps area and state procurement and assignment committees will have verified the information submitted and assayed the local civilian needs for each physician.

It is certainly true that a program of this kind cannot succeed unless there is full and complete co-operation from the medical profession and the

interested agencies. But if this does result, and we think it will, there is certainly no method thru which the medical needs of the present emergency can be met with greater efficiency and economy.

Major Sam Seeley, the director of the Procurement and Assignment Service, and the others who have assisted him in the development of the program are to be congratulated for an excellent approach to a very difficult problem.

PNEUMONIA CONTROL

The destiny of science is no more manifest than in the change that has taken place in the management of pneumonia since the advent of specific sera and chemotherapy. Until this epoch a patient suffering from pneumonia, whether in a well equipped hospital or treated under the most adverse surroundings, whether having an early diagnosis or none at all, his recovery or death depended largely on his own immunity. The treatment in vogue had little or no effect upon the frequency of complications and the mortality rate was twenty-five to thirty per cent. Pessimism and a sense of futility prevailed the minds of physicians when confronted by a severe case of pneumonia. When specific blood serum and a little later chemotherapy became available, a revolutionary change took place. The clinical laboratory was ready and waiting to be used and clinicians already knew how to make an early diagnosis. There is something very exciting to the human emotions in a new prospect of accomplishment and the mental process is quickened under this stimulant. In the use of the new methods early diagnosis was soon recognized as essential to the most successful treatment. This calls for prompt examination of sputum, blood cultures and blood counts in all cases suspected of having pneumonia. In obscure cases x-ray of the chest reveals the presence of the disease in many cases before the physical signs can be recognized. The degree of immunity in a given case can be determined by a microscopic test for homologous agglutinin in the blood.

Through this new approach to the problem of pneumonia the mortality rate has been reduced to a figure totaling well under fifteen per cent. The Pneumonia Control Program of the Kansas State Board of Health reports a mortality of only seven per cent for the year ending June 30, 1941. In the second year of this state wide program 591 patients who were medically indigent were given assistance. Through established pneumonia control stations laboratory services, drugs and specific sera are made immediately available to physicians who cooperate

with the program. These stations are in thirty-nine Kansas towns, located for the purpose of making the services useful as widely as possible over the state. The local laboratories at the designated stations are used for the required laboratory tests. These tests are paid for out of the pneumonia control program funds. The entire cost of the Kansas pneumonia control program for the last fiscal year was \$7,115.61, an average cost of \$12.03 per patient. The value of this program to the people of Kansas cannot be estimated in dollars. Its highest value lies in a remarkably low mortality rate among the patients treated. The program also has an educational value, and sets up a high standard for the treatment of pneumonia in all of the communities wherein it operates over the state.

So it is that from forlorn hope and a sense of futility the medical profession has moved to a position of knowledge and a plan of action for the control of pneumonia, formerly one of the most deadly of diseases.

CANCER CONTROL

CANCER OF THE STOMACH*

Howard E. Snyder, M.D.

Winfield, Kansas

Before the raid on Pearl Harbor the United States had fought in six major wars. These six major wars consumed a little more than fifteen years and 247,000 men lost their lives from battle wounds. In a fifteen year period, ending in 1939, 442,000 individuals lost their lives in automobile accidents. In the same period of fifteen years, approximately 600,000 individuals died of cancer of the stomach. In other words, almost three times as many died in peace time from cancer of the stomach as did men die of battle wounds in a like period when this country was actually at war. One out of every ten individuals dies of cancer. One-fourth to one-third of those who die of cancer, die of cancer of the stomach. It has been conservatively estimated that one-third to one-half of those who die of cancer might be saved if treatment were started in time.

If cancer is to be treated in time, an early diagnosis must be made. The most important factor in

public so that they may recognize symptoms which may mean cancer and seek competent advice and study early.

Every cancer starts as a local growth. For some unknown reason a cell or group of cells start to our program of cancer control is education of the multiply and grow in a wild and disorderly fashion. The usual laws of nature are ignored. This growth of abnormal tissue cells tends to invade and destroy surrounding tissues. Sooner or later it erodes the wall of a lymph vessel or a blood vessel and a few cells break loose in the lymph stream or blood stream and are carried to distant parts of the body. Then it is said that the cancer has spread or metastasis has taken place. In some cancers this spread through the lymph stream or blood stream occurs early. In others, it occurs quite late. Every cancer can be easily eradicated when it is yet a local growth. Once it has spread through the lymph stream the problem becomes much more difficult. Yet, even then a certain percentage may be cured. Once it has spread by the blood stream the situation is practically hopeless. Fortunately, few cancers spread early by the blood stream route.

Cancer is not contagious. One individual never acquires it from another. The surgeon does not acquire cancer in the operating room from a patient with cancer. You should also know that heredity probably plays no important part in cancer in so far as the human race is concerned. It may be true that in certain forms of cancer an individual may inherit a predisposition to the development of it, but cancer itself is not inherited.

You should also know the difference between a cancer or malignant tumor and a benign tumor. All cancers are tumors, but not all tumors are cancers. A benign tumor differs from a malignant tumor or cancer in that it tends to grow locally, only. Surrounding tissue is pushed aside but not invaded. Hence, a blood vessel or lymph vessel is never eroded and the benign growth never spreads to distant parts of the body. You are familiar with such benign tumors as moles, warts, fatty tumors, etc. Some benign tumors tend to become malignant or cancerous; hence, as a general rule, all benign tumors should be removed.

We do not know all there is to know concerning the cause of cancer. There are certain things, however, we do know about the cause of cancer which are quite important. We know that chronic irritation unquestionably plays an important part. Those exposed constantly to the irritating effects of sun and wind are much more prone to develop cancer of the skin than those who are not so exposed. We know that the Irishman who smoked a clay pipe with

* For several years the Society Committee on Control of Cancer has selected particular phases of that disease which it felt should be emphasized in lay educational activities. The topic chosen by the committee for 1941-1942 is cancer of the stomach. The above paper was prepared on behalf of the committee with the thought in mind that it might be of assistance to physicians in the presentation of cancer talks before lay groups. Reprint copies of the suggested talk will be forwarded to all of the county medical societies.

a short stem which became very hot was very prone to develop cancer of the lip at the exact spot where the pipe was held in his mouth. We know that a mole or a wart which is subject to the constant chafing of a shoe or waist band or collar band is also prone to become malignant or cancerous. We know that women who do not return for follow-up examinations after childbirth, who do not have lacerations or chronic irritations of the neck of the womb eliminated are perhaps the only ones who ever develop cancer in this situation. Hence, here is one field in which cancer may be prevented. There are many other examples where chronic irritation within or without plays a role in the development of cancer.

There is no drug, no serum, no diet which will cure cancer. Today there are only three approved weapons in the treatment of cancer. They are: surgery, x-rays and radium. Surgery includes the knife, the radio knife, electric needle, the cautery, all surgical instruments which may be used to remove or destroy a cancerous growth. X-rays and radium are particularly valuable in the treatment of cancer in that cancer cells are more susceptible to the destructive effect of x-rays and radium than are normal tissue cells. Surgery, x-rays and radium may be used singly or in any combination, depending upon the location and type of growth. Your physician must decide which is best in each individual case.

In Kansas during the last few years a rather intense campaign of public education has been in progress. Two years ago the subject of cancer of the skin was stressed in all public meetings. It was pointed out that there was no excuse for anyone dying of cancer of the skin. Every skin cancer should be recognized early and treated early. In the last few years the mortality from cancer of the skin in Kansas has been reduced approximately fifty per cent. Last year in public meetings the subjects of cancer of the breast and cancer of the uterus or womb were stressed. It was pointed out that at least seventy-five per cent of these should be cured. This year cancer of the stomach has been chosen as the subject for emphasis.

Cancer of the stomach accounts for more fatalities than does cancer of any other organ. Unfortunately, the diagnosis of cancer of the stomach is made so late that one-half of those so afflicted may be told that they have a hopeless cancer of the stomach at the time the diagnosis is made. In the remaining fifty per cent, in whom there seems hope of cure and in which an operation is performed, it is found at operation that fifty per cent of these have progressed beyond the hope of radical surgical cure. In other words, at the time the diagnosis of cancer of the stomach is established, only twenty-five per cent of those afflicted have a chance to survive. Of this

small group of twenty-five per cent, a rather large percentage survive five years following a radical operation. The great problem then in cancer of the stomach is early diagnosis. If an early diagnosis is to be made the public must be educated as to the early signs and symptoms which may mean cancer of the stomach.

The symptoms of cancer of the stomach may be grouped in four general classes. They depend somewhat upon the location of the growth in the stomach as well as upon the type of growth and other factors. In the first group, persistent indigestion develops suddenly, usually in middle life. This persistent indigestion is often manifested by a burning or gnawing sensation in the pit of the stomach. There is often a distaste for food, particularly for meat. Soda or an alkaline powder may relieve the distress at first, but later prove of no value. Nausea and vomiting may be a feature. In the second group are those cases in which "ulcer" symptoms may have been present off and on for a number of years. Usually with the development of a malignancy or cancer in the ulcer there is a change in the character of the symptoms, but this is not necessarily true. In the third group, signs of obstruction predominate. In this group are those cases in which the growth involves either the opening into the stomach or the opening out of the stomach. In the case in which the opening into the stomach is obstructed by the growth, difficulty in swallowing, pain or distress beneath the lower end of the breast bone following swallowing are the usual symptoms. In those cases in which obstruction occurs at the lower end of the stomach, distention of the stomach, vomiting of huge quantities of food, some of which was perhaps eaten one or two days before, may occur. In the fourth group the symptoms are those of anemia, such as weakness, shortness of breath, pale color, tired feeling, and so on. The anemia, a reduction in the number of red blood cells and hemoglobin, in cancer of the stomach may mimic anemia from any other cause. Its presence without any known cause always directs suspicion toward cancer of the stomach or cancer elsewhere in the digestive tract.

The patient presenting symptoms which are suggestive of cancer of the stomach is entitled to a very thorough diagnostic study. In addition to the routine complete physical examination and history, the individual should have blood counts, analysis of the stomach content, examination of the stool, x-ray studies of the stomach, small and large bowel and gall bladder. Sometimes the diagnosis is not made at the first x-ray examination and another x-ray examination may be indicated. Sometimes an exploratory operation is necessary. In as much as early and

radical surgery is the only treatment for cancer of the stomach, operation must not be delayed.

The group of individuals with ulcer symptoms should likewise have thorough diagnostic studies. They should follow to the letter the instructions of their physicians. When ulcer symptoms do not improve under medical management, surgery should be performed. This is particularly true when the ulcer involves the stomach proper, and in such cases improvement should be calibrated by repeated x-ray examinations. If there is not a progressive decrease in the size of the ulcer, it is in all probability a malignant ulcer or cancer and a surgical operation is imperative. Those patients with an anemia should likewise have complete studies of the stomach and intestinal tract. There are some authorities who feel that individuals with pernicious anemia or primary anemia are more prone to develop cancer of the stomach than the average individual. They feel that those with pernicious anemia should have x-ray examinations of the stomach at intervals not to exceed six months.

The practice of self medication with soda or alkaline powders must be discouraged. The practice of going to your physician and asking for a prescription for your "stomach trouble" is a bad one. Do not ask your physician for a prescription; ask him for a complete examination. When a diagnosis has been made, intelligent treatment can then be carried out.

If the public becomes as well informed concerning the symptoms of cancer as they are concerning the symptoms of tuberculosis, we shall see a great reduction in mortality from cancer just as we have seen, through the education of the public, a great reduction in the mortality from tuberculosis. Cancer of the stomach is now the chief offender, but cancer may involve any organ. We feel that there are four important steps which the public may assume in doing their bit in the program of cancer control. First, is a knowledge of the early signs or danger signals which may mean cancer. You have just heard a more or less detailed discussion of the signs or danger signals which may mean cancer of the stomach. Other early signs or danger signals which may mean cancer are: 1. Any persistent lump or thickening, especially in the breast. 2. Any unnatural discharge, particularly a bloody discharge, from any of the body openings. 3. Any sore which does not heal, particularly about the tongue, the mouth, the lips. 4. Any sudden change in the form or rate of growth of a mole or wart. 5. Persistent hoarseness, particularly when it develops in the absence of a cold.

The second part which the public may play in this program of cancer control is in having a yearly physical examination. We feel that women past

thirty and all women who have borne children should have an examination of the breasts and the pelvic area every six months. At the time of these examinations your doctor may discover some source of chronic irritation which should be removed. He may discover an early cancer of which you are unaware and which, in this early stage, may be easily cured. The third part the public must play in this program of cancer control is in knowing what to do when confronted with the signs and symptoms which may mean cancer and the answer is "Consult your family doctor." Unfortunately, there are in Kansas and in our neighboring states a number of quacks or quack institutions which cater to an unsuspecting public. They advertise their wares through the medium of the radio and any other medium which they can use without getting in trouble. One of the most notorious of these cancer quacks slipped a little and was convicted on a charge of using the mails to defraud and placed behind the bars of a Federal penitentiary. Many still prosper. The public must know that these advertising cancer quacks are not to be trusted and that the family doctor is the one to consult. If your family doctor is not prepared to complete the examination or the treatment, he is always prepared to direct you into the proper channels for further examination and treatment. The fourth, and another important part the public must play in the program of cancer control, is in the work of the Women's Field Army of the American Society for the Control of Cancer. This organization is now in its sixth year. Its prime motive is a reduction in the mortality from cancer. It is doing a great work in promoting the education of the public concerning the curability of early cancer. Each April the Women's Field Army conducts an enlistment campaign. The dollars procured in this enlistment campaign make possible the educational program for the coming year. Congress has by law declared April as Cancer Control Month. This year the Women's Field Army, The Kansas Medical Society and the State Board of Health will direct their united efforts in a cancer control program. By enlisting in the Women's Field Army during this month you may do your part in promoting this worthwhile project.

In conclusion may I remind you that cancer is second only to heart disease as a killer in the United States. There are 150,000 deaths a year from cancer; one-third to one-half of these are needless deaths. Early cancer can be cured by surgery, x-rays or radium. The periodic physical examination, knowledge of the danger signals which may mean cancer, consultation with the family doctor, and participation in the work of the Women's Field Army constitute the program the public should follow in this fight against cancer.

MEDICAL SCHOOL

FRACTURE OF THE ANKYLOSED CERVICAL SPINE

J. B. Weaver, M.D.*

C. B. Francisco, M.D.*

Kansas City, Kansas

Ankylosis of the cervical spine is not rare, but the fracture of such a pathologically formed "shaft" is apparently not common. The following two cases are therefore reported.

Case 1. A thirty-four year old man was admitted to the hospital July 9, 1932. A few hours previous to admission he had fallen down several stair steps and struck upon his back and the back of his head. He did not lose consciousness, but had immediate sensory and motor paralysis of the area below the nipple line.

This patient was known to have had an ankylosis of the entire spine for seventeen years. In addition there was fusion of both hips, both shoulders and both temporo-mandibular joints. There were numerous osteomata throughout the skeleton and myositis ossificans progressiva of muscles about the back, shoulders, face and hips.

The admission examination revealed the physical findings as previously indicated. In addition there was marked tenderness to palpation over the spines of the sixth and seventh cervical vertebrae and any attempt at motion of the neck was quite painful. A consulting neurologist's diagnosis was compression of the spinal cord at the level of the sixth and seventh cervical vertebrae.

The roentgenologist reported: "There is an extensive spondylitis of the cervical spine with numerous osteomata. There is obliteration of all joint spaces except that between the sixth and seventh cervical bodies which appears to be wider than normal. However, there is no displacement and the relation of the vertebrae one to another is correct."

Death occurred on the tenth day following the injury and was typical of that due to an ascending myelitis of the spinal cord. A necropsy was not obtained.

The roentgen pictures of this patient were destroyed so are not available for publication. However, a diagnosis of fracture of the cervical spine with compression of the cord at the level of the sixth and seventh cervical vertebrae can hardly be

denied, especially in the light of the findings in the following case.

Case 2. A fifty-five year old man, who was known to have a complete ankylosis of his entire spine for twenty years, was admitted to the University of Kansas Hospitals March 27, 1939. The day previous to admission, he tripped and fell while walking, and struck upon his forehead. He did not lose consciousness but had immediate paralysis of all four extremities.

Admission examination showed complete motor and sensory paralysis of both legs, the trunk to just above the nipple line, and both arms. Any attempt at manipulation of the neck produced severe pain.

The roentgenologist reported: "The cervical vertebrae present a "poker" spine. Between the third and fourth cervical bodies there is a break in continuity of ossification of the anterior spinous ligaments. There is approximately two mm. posterior displacement of the third and the fourth vertebrae. There is a transverse fracture through the base of the fourth spinous process." (Fig. 1.)



Fig. 1. Lateral view roentgenogram of cervical spine Case II.

Death occurred on the eighth day following injury. At the necropsy there was found a compression of the cord at the site of a fracture dislocation between the third and fourth cervical vertebrae. There was

*University of Kansas Hospitals, Kansas City, Kansas.

complete ankylosis of the vertebrae both above and below this site.

Injury with resultant cervical "shaft" fracture, cord compression and death might appear to be a constant menace and of relatively frequent occurrence to patients with fused cervical spines. An unprotected, rigid cervical spine extending beyond the thoracic cage protected dorsal spine, and topped by a cranium, which is an excellent target for blows, would seem to be more subject to major injury than a normal flexible spine. The rather minor type of accident in Case II, which produced a fracture by the exceedingly rare mode of hyperextension of the neck would seem to lend credence to this view. However, a study of the literature indicates that these fractures occur infrequently. The authors found only one other case report. Stiasny reported a case in which a thirty-six year old man fell, striking the back of his head on a window sill. There was no paralysis and the patient reported to a physician two days after the accident because of pain in his neck. The roentgen picture showed a cervical spine fused by a marked spondylitis. There was a fracture line between the fifth and sixth cervical bodies and through the neural arch. The picture was very similar to Fig. 1 with the exception of the site of injury and there was no displacement. The patient made a complete recovery and a roentgen picture taken twelve days after the accident was remarkable in that it showed marked callous formation at the fracture site.

Apparently the danger of cord injury is real. It occurred in two of the three cases in this report. A spinal cord encased in a rigid tube, no doubt loses its normal elasticity and thereby cannot escape compression so well, should displacement of the bony parts take place. In addition, the shearing force should be greater at the fracture site of a rigid ankylosed spine than of a normal flexible spine.

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Even in the most disastrous wars it is clear that the casualties are trivial in comparison with the annual morbidity and mortality from wholly preventable causes suffered by the population. Along with the expenditure of dizzy billions to combat foreign foes, it would seem the part of wisdom to devote a respectable amount of our defense energies and resources to the conquest of the ever present and very real foes within our domestic circle, if for no other reason than the fact that the first line of military defense is the health of the civilian population.—K. E. Miller, Med. Dir., United States Pub. Health Serv., Amer. Rev. of Tuber.

TUBERCULOSIS CONTROL

THE AMERICAN TRUDEAU SOCIETY

Harold G. Trimble, M.D.*

The American Trudeau Society is a natural outgrowth of the American Sanatorium Association. The Sanatorium Association was formed in the days when most of the medical problems, with reference to tuberculosis, revolved around the various tuberculosis institutions and when many of the men in tuberculosis work came by their interest because of their own personal history as tuberculosis patients. With increasing diagnostic facilities and with advances in various forms of treatment, general medical interest in diseases of the chest, including tuberculosis, was significantly increased and many young physicians became interested in these problems as such.

Theoretically, it seemed profitable, and practically it so developed, that contact between what one may call the "pure" specialist in tuberculosis and the internist, who while having other interests was intimately concerned with diseases of the chest, would benefit both. On this basis, then, with the cooperation of the National Tuberculosis Association, the American Trudeau Society was born—an organization of medical men with a nucleus of those interested primarily in tuberculosis and including, also, a group interested in general internal medicine.

The idea of such a society which would be inclusive rather than exclusive, that is, not confined to men who were primarily specialists in diseases of the chest, caught hold among the medical public, as evidenced by the rapid increase in members. Such an organization has a dual responsibility: first to push forward the already rapidly advancing knowledge with regard to the technical medical as well as public health aspects of tuberculosis; second, to see that the known facts are disseminated even more rapidly among medical men in general. These functions are best achieved through the work of strong active committees with as wide a geographic distribution as possible, and with a diversity of personnel to bring forth all aspects of the problem at hand. There are but few physicians of prominence in the field of tuberculosis or its closely allied specialties, who are not active members of the Trudeau Society. Members give generously of their time,

talent, and information to work out such special problems as may be referred to them, or such as they feel worthy of further investigation and study.

To provide information that is interesting, accurate and well thought through, to avoid mere novelties without overlooking new developments of intrinsic merit, and to review new phases of old problems, is no mean task. Such is the work of our program committee in arranging the annual meeting. If attendance is an index, their efforts have been crowned with success.

As new technics develop in the field of laboratory medicine in problems allied with diseases of the chest, it is extremely valuable that the procedures be independently evaluated, not by single individuals but by a group of physicians who are actively working in the same field, and who have the facilities and personnel to try out the particular procedure and evaluate it, without bias or undue enthusiasm. This is a task that our Committee on Standard Laboratory Procedures does and reports from this group are issued as promptly as possible for our information and guidance.

Developments in the fields of diagnosis and treatment are based largely upon technical developments in allied sciences. It is not always that these newer developments get to the medical student rapidly and effectively. Our Committee on Undergraduate Medical Education, consisting of men who are all experienced in teaching and alive to the needs of both student and medical school, is seeking more effective ways to reach this end.

The problem in post-graduate medical education is somewhat different. Practicing physicians are largely creatures of habit. We change but slowly technics we have learned and used so long. Only when we realize that something is really better, a distinct improvement and not merely different, will it be adopted. The purpose of the Committee on Post-graduate Medical Education is to make available as rapidly as possible knowledge of diagnostic technics in the field of pulmonary disease, particularly where it should be used the most, namely, the office of the physician in general practice. The realization today that tuberculosis in its earliest stages, when it is most curable, must be actually sought for, that it ordinarily is without signs or symptoms, is still somewhat of a mental hazard for men who were taught years ago that fever, cough, sputum, etc., are indicative of tuberculosis, and that proper skill with the eyes, fingers and ears is adequate for diagnosis. As many new methods of using the x-ray become simplified, more readily accessible, and less expensive, the known facts regarding their effective use need to be widely disseminated. The Committee

on Postgraduate Medical Education is seeking to analyze the results of actual methods that have already been put into practical use and to get such information not to the tuberculosis specialist alone but particularly to the man in general practice.

New methods of x-ray procedure in the diagnosis of pulmonary conditions are in the course of rapid development. Our Committee on X-ray Apparatus and Technique consists of men actively working in the application of x-ray to tuberculosis as a clinical problem as well as those working on technical improvement in existing apparatus. This group is in a position to evaluate the developments of the x-ray and to give this information to our members and the general medical public.

The tuberculosis sanatorium is, and should be, the focus around which the tuberculosis work of all kinds revolves. As the character of treatment changes, as more technical diagnostic procedures, such as bronchoscopy, develop, and as surgical collapse therapy grows in extent, there must necessarily be some alteration in the physical plant as well as the type of medical care available for the tuberculous patient. Our Committee on Tuberculosis Sanatorium Standards is now in the midst of evaluating these problems and will be able to report what is considered adequate current practice within the near future.

The American Trudeau Society policy, as originally adopted and reaffirmed upon numerous occasions, has been, that one seeking official certification as a specialist in tuberculosis should have a broad background in internal medicine. To that end the Society has a Committee on Cooperation with the American Board of Internal Medicine.

Thousands of professional workers, such as nurses, social workers, health officers, as well as many more members of the general population, have served as board members of tuberculosis associations, on seal sale committees, and in various other capacities. They have a real interest in the developments of technical problems in the field of tuberculosis. To give them authentic advice, advisory committees have been set up for the purpose of reviewing such literature of the National Tuberculosis Association as is already available as well as checking new publications as they are produced. The Committee on Educational Literature and the Committee on Medical Information must necessarily work in very close relation with these large groups of professional and lay persons interested in the general field of tuberculosis. This work to date has been effective, stimulating and productive of much good result.

This, in outline, is the general philosophy and its practical application as applied to the affairs of the

American Trudeau Society. Its work covers those phases of the medical aspects of tuberculosis that are mostly problems for the specialists, as well as those that have special appeal to the physician in general practice. Its effectiveness can continue only insofar as both these groups bring to it their current problems, and working through its committees, bring to bear jointly the sound advice and earnest counsel that is only theirs to give.—From Tuberculosis Abstracts, January, 1942.

NEWS NOTES

MILITARY SERVICES

The Procurement and Assignment Service at Washington is making rapid progress in its arrangements and plans of the placement of physicians in the military forces and in civilian defense activities. A description of this program was contained in the following release which was recently issued by the Procurement and Assignment Service:

"We are sending you this bulletin in order that you may have most recent information in regard to the Procurement and Assignment Service, and the situation as it pertains to all physicians, dentists, and veterinarians:

(1.) You may anticipate a rapid expansion of the armed service and a corresponding acceleration in the demands for medical, dental, and veterinarians personnel to meet these rapidly growing needs;

(2) 15,000—20,000 physicians, dentists and veterinarians have offered their services to date, and their enrollment forms are now being processed, i.e. being checked against the files of the National Roster punch card system made available to this office by the American Medical, Dental and Veterinary Medical Associations and other organizations, and further checked in the office of the Procurement and Assignment Service;

(3) Within ten days, the first notifications of those men who are cleared at the Roster office and the Procurement and Assignment Service as meeting the requisitions made by the armed services will be ready for transmission;

(4) Lists of such men who have volunteered from each State are being sent to the State Procurement and Assignment Chairmen for immediate check, in order that only those available may be asked at this time to accomplish application forms for commission in the Army or the Navy. These forms will be sent to these men individually;

(5) In general, every man under thirty-six who is physically fit should volunteer for active service in the Army or the Navy, if he is now or can be made available. The most urgent need is for men under thirty-six; however, many specialists up to forty-five will be needed at once. The Procurement and Assignment Service expects that the present needs of the armed services for medical personnel will be filled by those under forty-five. Other age groups will be held in readiness to fill requisitions when their services are desired;

(6) Corps Area Chairmen will be called to Washington, Friday, January 30th, to be informed of the complete plans of organization and the method by which the Procurement and Assignment Service will function down to the most remote county. Following this conference, meetings will then be held by the Corps Area Chairmen with the

members of the Corps Area committees and all their State chairmen for physicians, dentists, and veterinarians respectively. Within a few weeks, every physician, dentist, and veterinarian of the nation will receive an enrollment form from the office of the Procurement and Assignment Service. On this form all will be asked to volunteer for service in military, governmental, industrial, or civil agencies requiring their services for the duration of the war. Each will be asked to designate a first, second, third, and fourth choice of the many agencies requiring assistance;

(7) A pamphlet of information is being prepared by the Committee on Information and will be ready for distribution at an early date, copies of which will be available upon request to this office;

(8) Bulletins will be issued from time to time to all committees, state society secretaries, and national and state journal editors, in order that the entire profession may be kept up to date;

(9) Hundreds of letters from physicians are coming to this office asking questions in regard to the Procurement and Assignment Service. We, here, have attempted to answer these letters quickly and adequately in spite of temporary impediments incident to the establishment of a complete office. These have tended to slow us up but now that the organization is in the process of completion we hope to be able to keep you informed;

(10) At an early date the physical standards for commissions in military and governmental agencies will be published in order that by self-analysis, physicians, dentists and veterinarians may determine their ability to meet the requirements for commissions;

(11) A formal acknowledgment is being made to the thousands of volunteer enrollments as rapidly as possible. We hope in the future to answer correspondence in a more formal and personal manner. Rather than to delay, however, we find it expedient to answer your communication of recent date with this form letter. Kindly accept it as a personal message intended to keep you informed. If you, or any other physician, dentist, or veterinarian in your state, have any further questions, we suggest that the majority of these will be answered in the national and state journals. If your questions are unanswered, kindly communicate with the Washington office.

Accept the thanks of the Directing Board for your interest and co-operation.

For the Directing Board—Sam F. Seeley, M.D.,
Executive Officer Procurement and Assignment Service."

As is stated above an additional questionnaire form will be forwarded to all doctors of medicine in the country in the near future. Physicians will be given an opportunity therein to state the work they can accomplish and the work they would prefer to accomplish during the present emergency. It is understood too that physicians volunteering their services thru the medium of this questionnaire will be provided with lapel buttons signifying their offer of their services.

The War Department and the Navy Department announced recently that henceforth commissions in the Medical Corps will be issued only upon the recommendation of the Procurement and Assignment Service.

The Procurement and Assignment Service has announced, also, that Corps Area committees, state committees and county committees on that subject are to be organized. It is understood that these committees will assist the national committee in the recommendation of physicians for particu-

lar duties, in their placement and deferment for civilian needs, and in numerous other matters.

The Seventh Corps Area Committee on Procurement and Assignment, the Corps Area to which Kansas belongs, consists of the following persons: Dr. Roy W. Fouts of Omaha, Nebraska; Dr. F. L. Loveland of Topeka; Dr. F. A. Pierson, dentist, of Omaha, Nebraska; Dr. A. W. Bryan, dentist, of Iowa City, Iowa; and Dr. H. D. Bergman, veterinarian, of Ames, Iowa, and one representative of hospitals and one of medical education which have not as yet been appointed. The medical division of the Kansas State Committee on Procurement and Assignment includes Dr. F. L. Loveland of Topeka as Chairman, Dr. C. D. Blake of Hays, Dr. N. E. Melencamp of Dodge City, Dr. C. C. Nesselrode of Kansas City, Dr. John N. Porter of Concordia, Dr. H. N. Tihen of Wichita, Dr. C. S. Huffman of Columbus, Dr. W. M. Mills of Topeka, and Dr. Marion Trueheart of Sterling. The county committees have not as yet been completed.

SELECTIVE SERVICE

The following bulletin in regard to occupational deferment of medical doctors, dentists and doctors of veterinary medicine was released on January 28 by the national headquarters of the Selective Service System in Washington:

"Information previously distributed by this Headquarters clearly indicates an over-all shortage of medical doctors, dentists, and doctors of veterinary medicine in the Nation. Since war was declared, the shortage of these professional men has become acute. It is now manifest that every qualified doctor, dentist, and veterinarian must serve where he can render the greatest professional service to the Nation.

In order to accomplish this purpose, the President, by Executive Order, has formed the Procurement and Assignment Service, under the Office of Defense Health and Welfare Services. This Service was formed primarily for the purpose of gathering and making available information with respect to the supply of qualified practitioners in the fields of medicine, dentistry, and veterinary medicine, with a view of securing the most effective allocation of medical manpower as indicated by the requirements of the armed forces, civilian needs, and industrial medicine.

To work with the headquarters of this Service in Washington, there is being organized a committee for each Corps Area in the Continental United States. Each committee will consist of five doctors, two dentists, and one veterinarian. The committees have been accepted as advisors to the nine Corps Area Surgeons, to the Naval District Surgeons, and to the Regional Medical Officers of the Office of Civilian Defense, and will operate not only through the subdivisions of the medical, dental, and veterinary associations, but also with the profession at large, in securing information and giving advice.

When considering the classification of any registrant who is a qualified medical doctor, dentist, or doctor of veterinary medicine, the Director of Selective Service desires that local boards, through the State Director, shall consult

the Procurement and Assignment Committee of the Corps Area for information as to the availability of qualified medical doctors, dentists, and doctors of veterinary medicine in the community. This information shall be considered by the local board in determining the registrant's classification. The Executive Order referred to in no way affects the authority of the Selective Service System to classify registrants. The procedure has been established for the purpose of making such information available to local boards.

For the convenience of the State Director and the local boards, the names and addresses of the Chairmen of the nine Corps Area Committees of the Procurement and Assignment Service are listed below:

First Corps Area—Dr. W. G. Phippen, Salem, Massachusetts.

Second Corps Area—Dr. A. W. Booth, Elmira, New York.

Third Corps Area—Dr. A. M. Shipley, Baltimore, Maryland.

Fourth Corps Area—Dr. Edgar Greene, Atlanta, Georgia.

Fifth Corps Area—Dr. E. L. Henderson, Louisville, Kentucky.

Sixth Corps Area—Dr. Charles H. Phifer, Chicago, Illinois.

Seventh Corps Area—Dr. Roy W. Fouts, Omaha, Nebraska.

Eighth Corps Area—Dr. Sam E. Thompson, Kerrville, Texas.

Ninth Corps Area—Dr. Charles A. Dukes, Oakland, California.—Lewis B. Hershey, Director."

WORKMEN'S COMPENSATION

The Society Committee on Industrial Medicine has arranged to hold a post-graduate meeting on Industrial Medicine and Workmen's Compensation at the Hotel Allis in Wichita on Tuesday, March 3.

The major speaker for the meeting will be Dr. Henry H. Kessler of Newark, New Jersey, who is internationally known for his work in this field.

The meeting will commence at 10:00 a.m. and will continue thru morning, afternoon and evening sessions.

All members of the Society are invited to attend.

PHYSICIAN AGE GROUPS

The Society Committee on Medical Preparedness recently requested the central office to prepare a report showing the age group of Kansas doctors of medicine by county and councilor districts. The information shown in this report by councilor districts is as follows:

COUNCILOR	AGE GROUP						
DISTRICTS	Under 36	36-40	41-45	46-55	56-65	Over 65	Total
First	17	10	5	15	27	28	102
Second	10	12	11	17	36	34	120
Third	11	20	15	35	50	67	198
Fourth	15	27	13	32	52	65	204
Fifth	16	26	17	16	43	42	160
Sixth	33	32	36	56	82	75	314
Seventh	10	14	10	16	32	25	107
Eighth	13	8	5	15	26	27	94
Ninth	4	4	2	10	8	5	33
Tenth	3	3	5	11	14	18	54
Eleventh	10	5	2	3	12	12	44
Twelfth	8	1	8	11	8	7	43
Totals	150	162	129	237	390	405	1,473

The above figures do not include approximately 150 Kansas physicians who are already serving in the military

forces, approximately fifty women physicians in the State, and approximately 300 other physicians who are retired, out of the State, or otherwise unavailable for military duty.

If the Army and the Navy choose to call all physicians up to forty-five years of age for military service, it is obvious in the above study that approximately 1100 or 1200 physicians would remain in Kansas for civilian medical needs.

ANNUAL SESSION

Plans for the 1942 annual session are rapidly being completed.

The meeting is to be held in the Wichita Forum on May 11-14, Monday, Tuesday, Wednesday and Thursday.

The Wichita Forum is to be renovated and redecorated and thus presents an ideal place for this year's meeting.

As might be anticipated under war conditions the Program Committee has experienced some cancellations and some difficulty in completing arrangements for the scientific program. Their plans, however, are almost complete and an interesting and excellent list of guest speakers has been obtained.

The Committee on Scientific Exhibits, of which Dr. Howard E. Snyder of Winfield is chairman, desires to receive applications from members who would be willing to present scientific exhibits.

The following technical exhibit reservations have been made to date:

- A. S. Aloe Company, St. Louis, Missouri.
- Petrogalar Laboratories, Chicago, Illinois.
- M & R Dietetic Laboratories, Inc., Columbus, Ohio.
- Gerber Products Company, Fremont, Michigan.
- Mead Johnson & Company, Evansville, Indiana.
- Pet Milk Sales Corp., St. Louis, Missouri.
- J. R. Siebrandt Mfg. Company, Kansas City, Missouri.
- Philip Morris & Company, Ltd., New York, New York.
- William S. Merrell Company, Cincinnati, Ohio.
- Luzier's Inc., Kansas City, Missouri.
- John Wyeth and Bros., Inc., Philadelphia, Pennsylvania.
- Eli Lilly and Company, Indianapolis, Indiana.
- Smith, Kline & French Laboratories, Philadelphia, Pennsylvania.
- The Medical Protective Company, Fort Wayne, Indiana.
- E. R. Squibb & Sons, New York, New York.
- Riggs Optical Company, Kansas City, Missouri.
- Quinton-Duffens Optical Company, Topeka, Kansas.
- Parke-Davis and Company, Detroit, Michigan.
- The Borden Company, New York, New York.
- American Hospital Supply Corp., Chicago, Illinois.
- Burroughs Wellcome & Company, Inc., New York, New York.
- Holland-Rantos Company, Inc., New York, New York.
- Cerophyl Laboratories, Inc., Kansas City, Missouri.
- C. B. Fleet Company, Inc., Lynchburg, Virginia.
- Mid-West Surgical Supply Company, Inc., Wichita, Kansas.
- A. J. Griner Company, Kansas City, Missouri.
- The Mennen Company, Newark, New Jersey.
- Abbott Laboratories, North Chicago, Illinois.
- W. E. Isle Company, Kansas City, Missouri.
- American Optical Company, Kansas City, Missouri.
- General Electric X-Ray Corp., Chicago, Illinois.
- Camel Cigarettes, New York, New York.
- S. H. Camp & Company, Jackson, Michigan.

Ortho Products Inc., Linden, New Jersey.

Greb X-Ray Company, Kansas City, Missouri.

Davis and Geck, Inc., Brooklyn, New York.

Although physicians are probably busier at the present time than they have been in many years, it is believed that the opportunity for post-graduate instruction is of unusual value at the Society annual sessions and it is hoped therefore that attendance at the 1942 annual meeting will be excellent.

MEDICAL SCHOOL CLINIC

The following announcement was recently received from the University of Kansas School of Medicine:

"The post-graduate clinic of the University of Kansas School of Medicine, which has been held annually during the Easter vacation will not be held this spring. This decision was made by the faculty following the announcement of the Board of Regents that the Easter vacation has been abolished to allow commencement to take place at an earlier date. Physical facilities of the Medical School prohibit the meeting of the post-graduate clinic at the time that the Medical School curriculum is in progress. It is hoped that the curriculum can be arranged for the meetings to be held at a later date. If it can, an announcement will be forthcoming."

EXAMINATION DATE CHANGED

The Kansas State Board of Medical Registration and Examination has announced that the next examination given by the Board will be held at the Wyandotte High School in Kansas City, Kansas, on June 2-3, instead of on June 16-17 as previously announced. The change in dates was made by reason that the University of Kansas School of Medicine has advanced its graduation date this year to June 1.

MENNINGER FOUNDATION

After several years of planning, the Menninger Foundation was organized and incorporated under the laws of Kansas in April, 1941, with headquarters in Topeka. The purposes of this new non-profit psychiatric foundation are four-fold:

1. Provisions for psychiatric education, especially the training of young physicians in psychiatry. The shortage of well-trained psychiatrists will presently become acute in relation to the requirements of World War II and the post-war period.
2. Encouragement of research in psychiatric and psychological fields.
3. Making available psychiatric treatment for patients in the low income bracket.
4. Prevention of mental illness, especially through development of child psychiatry and application of psychiatric knowledge to education and child-rearing.

In addition to local officers, the following trustees have been elected: Dr. Winfred Overholser, St. Elizabeth's Hospital, Washington, D. C.; Mrs. Albert Lasker, New York and Chicago; Dr. John C. Whitehorn, Johns Hopkins University, Baltimore; Mrs. Lucy Stearns McLaughlin, Santa Fe, New Mexico; Dean J. Roscoe Miller, Northwestern University Medical School, Chicago; Mrs. Sidney C. Borg.

Jewish Board of Guardians, New York City; George E. Hite Jr., Milbank, Tweed and Hope, New York City.

The Menninger Foundation has already initiated several projects from the financial gifts which enabled it to make a modest beginning. Grants have been made for a ten-year study of the place of occupational therapy in psychiatric treatment, for a seminar and special Bulletin on Military Psychiatry and the distribution of this information to physicians on the Medical Advisory Boards of the entire country, and for research in the use of hypnosis in emergency psychotherapy and in substantiating newer psychiatric theories. Other projects are to follow.

KANSAS OBSTETRICAL AND GYNECOLOGICAL SOCIETY

The Kansas Obstetrical and Gynecological Society will hold its next meeting on Friday, March 20, in Dodge City. This will be a joint meeting with the Ford County Medical Society. Dinner will be served at 6:30 p.m. at the Hotel Lora Locke and the scientific papers will follow the dinner.

Dr. W. F. Mengert of the Obstetrical and Gynecological Department of the University of Iowa will be the guest speaker. His topic will be "A Consideration of Dystocia and of Practical Methods of Estimating Pelvic Capacity."

It is the hope of the program chairman and the officers of the Kansas Obstetrical and Gynecological Society that all members of The Kansas Medical Society who reside close enough to Dodge City will attend the meeting. Dr. Megert is an excellent speaker and is distinguished in his field.

SCIENTIFIC EXHIBITS

The Committee on Scientific Exhibits is particularly anxious to have Kansas physicians participate in the Scientific Exhibit Section this year. The war will no doubt limit the number of exhibits by men from without the State. A number of the committees of The Kansas Medical Society will prepare exhibits. However, it is very desirable that a large number of individuals should prepare appropriate exhibits. The Committee is particularly anxious to have exhibits relating to traumatic surgery or some phase of war surgery. Application blanks may be secured from the Chairman of the Committee, Dr. Howard E. Snyder of Winfield.

SOLDIERS AND SAILORS ACT

It is believed that members now serving in the military forces and others who will do so in the future will be interested in having information concerning the Soldiers and Sailors Civil Relief Act passed by Congress, wherein provision was made for deferment and waiver of certain tax, insurance and other financial obligations due from persons engaged in military duty.

Since the Act is lengthy, space does not permit its reproduction in full. Certain salient excerpts therefrom, however, are as follows:

Article I—General Provisions

"In order to provide for, strengthen, and expedite the national defense under the emergent conditions which are threatening the peace and security of the United States and

to enable the United States the more successfully to fulfill the requirements of the national defense, provision is hereby made to suspend enforcement of civil liabilities, in certain cases, of persons in the military service of the United States in order to enable such persons to devote their entire energy to the defense needs of the Nation, and to this end the following provisions are made for the temporary suspension of legal proceedings and transactions which may prejudice the civil rights of persons in such service during the period herein specified over which this Act remains in force.

The provisions of this Act shall apply to the United States, the several States and Territories, the District of Columbia, and all territory subject to the jurisdiction of the United States, including the Philippine Islands while under the sovereignty of the United States, and to proceedings commenced in any court therein, and shall be enforced through the usual forms of procedure obtaining in such courts or under such regulations as may be by them prescribed.

Article III—Rent, Installment Contracts, Mortgages

No eviction or distress shall be made during the period of military service in respect of any premises for which the agreed rent does not exceed \$80 per month, occupied chiefly for dwelling purposes by the wife, children, or other dependents of a person in military service, except upon leave of court granted upon application therefor or granted in an action or proceeding affecting the right of possession.

On any such application or in any such action the court may, in its discretion, on its own motion, and shall, on application, unless in the opinion of the court the ability of the tenant to pay the agreed rent is not materially affected by reason of such military service, stay the proceedings for not longer than three months, as provided in this Act, or it may make such other order as may be just.

No person who prior to the date of approval of this Act has received, or whose assignor has received, under a contract for the purchase of real or personal property, or of lease or bailment with a view to purchase of such property, a deposit or installment of the purchase price from a person or from the assignor of a person who, after the date of payment of such deposit or installment, has entered military service, shall exercise any right or option under such contract to rescind or terminate the contract or resume possession of the property for nonpayment of any installment falling due during the period of such military service, except by action in a court of competent jurisdiction: *Provided*, That nothing contained in this section shall prevent the modification, termination, or cancellation of any such contract, or prevent the repossession or retention of property purchased or received under such contract, pursuant to a mutual agreement of the parties thereto, or their assignees, if such agreement is executed in writing subsequent to the making of such contract and during or after the period of military service of the person concerned.

No sale under a power of sale or under a judgment entered upon warrant of attorney to confess judgment contained in any such obligation shall be valid if made during the period of military service or within three months thereafter, unless upon an order of sale previously granted by the court and a return thereto made and approved by the court.

No court shall stay a proceeding to resume possession of a motor vehicle, tractor, or the accessories of either, or for an order of sale thereof, where said motor vehicle, tractor, or accessories are encumbered by a purchase money mort-

gage, conditional sales contract, or a lease or bailment with a view to purchase, unless the court shall find that fifty per centum or more of the purchase price of said property has been paid, but in any such proceeding the court may, before entering an order or judgment, require the plaintiff to file a bond, approved by the court, conditioned to indemnify the defendant, if in military service, against any loss or damage that he may suffer by reason of any such judgment or order should the judgment or order be set aside in whole or in part.

Article IV—Insurance

The benefits of this article shall apply to any person in military service who is the holder of a policy of life insurance, when such holder shall apply for such benefits on a form prepared in accordance with regulations which shall be prescribed by the Administrator of Veterans' Affairs. Such form shall set forth particularly that the application therein made is a consent to such modification of the terms of the original contract of insurance as are made necessary by the provisions of this article and by receiving and filing the same the insurer shall be deemed to have assented thereto, to the extent, if any, to which the policy on which the application is made is within the provisions of this article. The original of such application shall be sent by the insured to the insurer, and a copy thereof to the Veterans' Administrator.

The benefits of this Act shall be available to any person in military service in respect of contracts of insurance in force under their terms up to but not exceeding a face value of \$5,000, irrespective of the number of policies held by such person whether in one or more companies, when such contracts were made and a premium was paid thereon before the date of approval of this Act or not less than thirty days before entry into the military service; but in no event shall the provisions of this article apply to any policy on which premiums are due and unpaid for a period of more than one year at the time when application for the benefits of this article is made or in respect of any policy on which there is outstanding a policy loan or other indebtedness equal to or greater than 50 per centum of the cash surrender value of the policy.

No policy which has not lapsed for the nonpayment of premium before the commencement of the period of military service of the insured, and which has been brought within the benefits of this article, shall lapse or be forfeited for the nonpayment of premium during the period of such service or during one year after the expiration of such period: *Provided*, That in no case shall this prohibition extend for more than one year after the date when this Act ceases to be in force.

In the event that the military service of any person being the holder of a policy receiving the benefits of this article shall be terminated by death, the amount of any unpaid premiums, with interest at the rate provided for in the policy for policy loans, shall be deducted from the proceeds of the policy and shall be included in the next monthly report of the insurer as premiums paid.

If the insured does not within one year after the termination of his period of military service pay to the insurer all past due premiums with interest thereon from their several due dates at the rate provided in the policy for policy loans, the policy shall at the end of such year immediately lapse and become void, and the insurer shall thereupon become liable to pay the cash surrender value thereof, if any: *Provided*, That if the insured is in the military service when this Act ceases to be in force, such lapse shall occur and

surrender value be payable at the expiration of one year after the date when this Act ceases to be in force.

Article V—Taxes and Public Lands

The provisions of this section shall apply when any taxes or assessments, whether general or special, falling due during the period of military service in respect of real property owned and occupied for dwelling, agricultural, or business purposes by a person in military service or his dependents at the commencement of his period of military service and still so occupied by his dependents or employees are not paid.

When any person in military service, or any person in his behalf, shall file with the collector of taxes, or other officer whose duty it is to enforce the collection of taxes or assessments, an affidavit showing (a) that a tax or assessment has been assessed upon property which is the subject of this section, (b) that such tax or assessment is unpaid, and (c) that by reason of such military service the ability of such person to pay such tax or assessment is materially affected, no sale of such property shall be made to enforce the collection of such tax or assessment, or any proceeding or action for such purpose commenced, except upon leave of court granted upon an application made therefor by such collector or other officer. The court thereupon may stay such proceedings or such sale, as provided in this Act, for a period extending not more than six months after the termination of the period of military service of such person.

When by law such property may be sold or forfeited to enforce the collection of such tax or assessment, such person in military service shall have the right to redeem or commence an action to redeem such property, at any time not later than six months after the termination of such service, but in no case later than six months after the date when this Act ceases to be in force; but this shall not be taken to shorten any period, now or hereafter provided by the laws of any State or Territory for such redemption.

Whenever any tax or assessment shall not be paid when due, such tax or assessment due and unpaid shall bear interest until paid at the rate of six per centum per annum, and no other penalty or interest shall be incurred by reason of such nonpayment. Any lien for such unpaid taxes or assessment shall also include such interest thereon.

The Secretary of War, the Secretary of the Navy, and the Secretary of the Treasury shall make provision in such manner as each may deem appropriate for his respective department, to insure the giving of notice to persons in the military service under their respective jurisdictions, of the benefits accorded by this section and the action made necessary to claim those benefits in each case.

Citizens of the United States who serve with the forces of any nation with which the United States may be allied in the prosecution of any war in which the United States engages while this Act remains in force shall be entitled to the relief and benefits afforded by this article, if such service is similar to military service as defined in this Act, and if they are honorably discharged and resume United States citizenship or die in the service of the allied forces or as a result of such service.

The collection from any person in the military service of any tax on the income of such person, whether falling due prior to or during his period of military service, shall be deferred for a period extending not more than six months after the termination of his period of military service if such person's ability to pay such tax is materially impaired by reason of such service. No interest on any

amount of tax, collection of which is deferred for any period under this section, and no penalty for nonpayment of such amount during such period, shall accrue for such period of deferment by reason of such nonpayment. The running of any statute of limitations against the collection of such tax by distraint or otherwise shall be suspended for the period of military service of any individual the collection of whose tax is deferred under this section, and for an additional period of nine months beginning with the day following the period of military service. The provisions of this section shall not apply to the income tax on employees imposed by section 1400 of the Federal Insurance Contributions Act.

Article VI—Administrative Remedies

In any proceeding under this Act a certificate signed by The Adjutant General of the Army as to persons in the Army or in any branch of the United States service while serving pursuant to law with the Army of the United States, signed by the Chief of the Bureau of Navigation of the Navy Department as to persons in the United States Navy or in any other branch of the United States service while serving pursuant to law with the United States Navy, and signed by the Major General Commandant, United States Marine Corps, as to persons in the Marine Corps, or in any other branch of the United States service while serving pursuant to law with the Marine Corps, or signed by an officer designated by any of them, respectively, for the purpose, shall when produced by prima facie evidence as to any of the following facts stated in such certificate:

That a person named has not been, or is, or has been in military service; the time when and the place where such person entered military service, his residence at that time, and the rank, branch, and unit of such service that he entered, the dates within which he was in military service, the monthly pay received by such person at the date of issuing the certificate, the time when and the place where such person died in or was discharged from such service.

This Act shall remain in force until May 15, 1945: *Provided*, That should the United States be then engaged in a war, this Act shall remain in force until such war is terminated by a treaty of peace proclaimed by the President and for six months thereafter."

BLOOD AND PLASMA BANKS

The University of Kansas School of Medicine recently announced that it has completed arrangements for blood banks and plasma banks, thus making blood available at all times. Special apparatus has been installed for a closed system for the collection, storage, recovery and dispensing of the blood and plasma.

It is intended for the blood for the banks to be supplied by voluntary donors.

OBSTETRICAL AND GYNECOLOGICAL CONGRESS

The Second American Congress on Obstetrics and Gynecology is to be held in St. Louis, Missouri, on April 6-10.

On Monday, April 6, there will be a general "Obstetric Information Please" program with a moderator and four experts, which will be repeated again on Wednesday for "Shock and Hemorrhage" and on Friday for "Economics."

A special feature of the meeting will be the daily consultation service at 3:30 p.m., with fifty nationally-known physicians available for fifteen minute consultations through a registration system for individual physicians who wish advice on specific problems. The usual round table discussions have been arranged for sectional meetings.

This meeting, as most members know, is one of the foremost post-graduate events in the country. The Society Committee on Maternal Welfare plans to bulletinize all of the county medical societies suggesting that Kansas members interested in obstetrics and gynecology attend. Since this meeting is close to Kansas it is probable that a considerable number of Kansas physicians will attend.

CIVILIAN DEFENSE

The Society Committee on Medical Preparedness issued the following bulletin pertaining to civilian defense, to the presidents and secretaries of the county medical societies and the official representatives on January 8:

"We have enclosed copies of two important bulletins (Medical Defense Division Bulletins Nos. 1 and 2) which were issued recently by the Office of Civilian Defense in Washington.

As will be noted, these pertain to preparations and procedures for the provision of emergency medical care in the event of air raids, sabotage or similar disasters.

The Office of Civilian Defense strongly urges that every county medical society and hospital take immediate action to organize and maintain facilities of this kind.

This committee feels that this request is a particularly important one and it would like, therefore, to submit the following recommendations to your society:

1. That we not have the feeling our location in the central part of the county makes these preparations inapplicable to us; that we realize fully there is no certainty about air raids and sabotage in modern warfare; and that we, also, realize it is our duty to provide complete and efficient preparations in all phases of the present emergency, regardless of our opinions about proximity of danger or need.

2. That with this thought in mind, your society or county take immediate steps to develop a program of this kind.

3. That the program be organized in every detail and be very strictly maintained if your county is closely situated to defense industries, railway centers, oil production and storage, large wheat elevators, an army cantonment or similar facilities wherein attack or sabotage might be anticipated.

4. That if your county has no hospital, if it has only one or several physicians, or if there are other reasons wherein it would be difficult, impossible or impractical to organize the complete program recommended, that meetings and discussions be held and plans be prepared to provide answers to questions of the following kind: In the event a disaster should occur, where will the injured be treated? Will physicians, pharmacists, nurses, ambulances and other means of assistance be available on a moment's notice and will each know what to do without delay and difficulty? Are sufficient quantities of medical and other supplies, of the type needed in an emergency of this kind, available? (Seemingly, in instances where the entire program cannot be planned, it would be very advisable for physicians to meet with allied professions and agencies for the preparation of plans which can be instituted immediately in any emergency. The emergency service teams in

such instances would undoubtedly be smaller in number and less complex, but they can nevertheless be very efficient.)

5. That the physicians in each county offer their services to their local defense councils and that these councils be fully acquainted with the preparations being made by the local medical profession on the above and similar subjects. That wherever possible, arrangements be made to have a physician serve on the local defense council in order that efforts between the medical profession and the council may be completely coordinated.

The nation will rely extensively upon the medical profession throughout the present war. The services of many physicians will be utilized in the military forces, many others will need to be available for emergency use in disaster areas, and the remainder will accomplish equally important assistance at home for the civilian population. Those of us who remain at home must fully assume responsibility for the development and execution of programs of the above kind. The programs are entirely medical in nature and the lay public will rely implicitly upon us to provide all forms of medical help needed.

If your society has not as yet appointed a medical preparedness committee it should certainly do so without delay. Efficient committees of this kind will be of very great importance in the handling of the responsibilities which will be entrusted to the medical profession throughout the war. Likewise, in the case of multi-county medical societies, it would seem advisable for each of the component counties thereof to maintain its own committee on this subject.

Very truly yours,

Medical Preparedness Committee
C. D. Blake, M.D., Chairman."

Medical Defense Bulletin No. 1 issued by the United States Office of Civilian Defense was published in the December issue of the Journal. Excerpts from Medical Defense Bulletin No. II released by the same source are as follows:

"EQUIPMENT AND OPERATION OF EMERGENCY MEDICAL FIELD UNITS

1. The Field Casualty Service: As recommended in Bulletin No. 1 of the Medical Division, Emergency Medical Field Units should be established in all approved general hospitals, both voluntary and governmental, located in coastal States and in industrial centers of the interior. The plan of organization and size of the Emergency Field Units for hospitals of various sizes and the total number of Field Units recommended on a population basis are outlined in Bulletin No. 1.

The Emergency Medical Field Units of a hospital are composed of two or more squads, so that at least one squad is on first call during each twelve-hour period of the day. In larger hospitals reserve squads should be available at the call of the Control Center in the event that multiple sites of disaster should require the manning of additional Casualty Stations and First-Aid Posts. All members of Emergency Medical Field Units should be systematically drilled in first-aid procedures.

To be prepared to respond promptly and effectively, Emergency Medical Units should also participate in field drills. These drills should be called by the local defense authority and should include police and fire auxiliaries, rescue squads, stretcher teams, transport and canteen services so that the local protection services may be integrated.

During the present period of preparation, Medical Field Units should be related to hospitals. Prompt availability in the event of sudden and unexpected disaster can be expected

only of Units organized largely from the interne and resident staffs. It is advisable to designate an assistant surgical resident or surgical interne as Squad Leader. In order not to deplete the surgical staff of the hospital, other members of Emergency Squads may be derived from the medical, pediatric, and other nonsurgical divisions of the hospital.

1. Reserve Squads.—In the event of the more remote possibility of prolonged and continuous need for service in Casualty Stations and First-Aid Posts, it would become necessary to replace most of the hospital personnel assigned to the Field Casualty Service. Reserve squads made up of medical, nursing, and trained volunteer personnel from the community would carry the major responsibilities for the field service. Until the need is demonstrated, it will be simpler and more efficient to concentrate the primary organization of Emergency Medical Field Units for the most part within approved hospitals.

In hospitals whose resident staff should not be depleted even for a temporary emergency, the primary Medical Field Unit may be organized in part or even wholly from physicians and nurses engaged in private practice in the community.

2. Operation of Field Casualty Service.—The operation of the Field Casualty Service may be sketched as follows: Air raid warnings will come to the local Control Center from the military establishments in the area and will be relayed to the proper Civilian Defense Officers. Information concerning the location and extent of local damage will be transmitted promptly to the Control Center by Air Raid Wardens and other observers. Using a spot map showing the location of hospitals and sites for Casualty Stations, the Control Center or its substation will call out an appropriate number of Emergency Medical Field Units.

The squads of the Emergency Medical Units which have responded will proceed to the sites to which they have been directed by the Control Center or its substation and set up Casualty Stations. When indicated, the squad leader in charge of a Casualty Station may dispatch one or more teams of physicians, nurses, and nursing auxiliaries to establish First-Aid Posts at sites closer to the disaster. The establishment of fixed First-Aid Posts and Casualty Stations is not at present contemplated.

a. Casualty Stations.—The Casualty Station will occupy a predetermined site such as the clinic of a hospital, health department or voluntary agency, a health center or substation, a school basement or other suitable place which provides shelter, protection, and accessibility. It should be located if possible on a side street so that ambulances will not block main thoroughfares. The sites selected for Casualty Stations should be numbered and indicated on a spot map of the community. The Casualty Station will:

1. Serve as a center from which medical teams may be sent closer to the disaster if required.

2. Care for persons with minor injuries and for those suffering from nervous shock and hysteria until they may be permitted to return to their homes or to temporary shelters. This will protect hospitals from the burden of minor casualties which would interfere with the work of caring for the seriously injured.

3. Keep a record of all persons treated at the Station and see that all casualties transferred to a hospital are tagged.

The Casualty Station is to be supplied with stretchers, collapsible cots, and blankets from medical depots located at sites from which the transportation of Emergency Medical Service is derived. Eight stretchers, twenty-four cots,

and sixty-four blankets should be available per 10,000 population for issue to Casualty Stations as the need arises. Where kitchen tables are not available at the location of a Casualty Station, two pairs of saw horses, each thirty-six inches high, may be required, upon which stretchers may be placed to serve as dressing tables. Stretcher teams and rescue squads will obtain their stretchers at Casualty Stations.

b. First-Aid Posts.—The First-Aid Post will occupy a temporary location usually close to the scene of disaster and will:

1. Care for the more severely injured, preparatory to their transfer to a hospital. No surgery other than emergency first aid is contemplated.

2. Classify the casualties so as to expedite the transfer of the seriously injured to a hospital a most important responsibility which requires surgical judgment.

3. Direct the stream of ambulatory and of slightly injured stretcher patients and those suffering from nervous shock or hysteria to a Casualty Station.

4. Tag all casualties immediately. Maintain entries in Casualty Record Book of all persons receiving first aid. (A nurse or nurse's aide should be responsible for these records.)

II. Equipment for Emergency Medical Field Units.—The following lists include only the minimum medical and surgical equipment required for emergency treatment at the site of a disaster. Provision for other than essential minor surgery has purposely been omitted.

The equipment for each physician and his team is to be carried in two portable boxes provided with handles. These two boxes should be of the same size (15 by 20 by 8 inches), and they may be packed conveniently in the ambulance or other vehicle transporting the Emergency Squad to the site of the Casualty Station. The provision in separate containers of working supplies for each physician will permit the squad of a Casualty Station to split off one or more teams of physician and assistants who can be dispatched with their equipment to set up advanced First-Aid Posts.

a. List No. 1.—Equipment for a First-Aid Post.—(Working supply for one physician's team). List No. 1 indicates the medical and surgical equipment for each physician of an Emergency Medical Field Unit and his team of nurse and orderly or nurses' aide. One or more such teams man a First-Aid Post. First-Aid Posts are subsidiary to a Casualty Station which will furnish replacements of drugs and surgical supplies.

Cases, carrying, waterproof 2

INSTRUMENTS

Scissors, surgical, 5½" curved	2
Scissors, surgical, Mayo 5½" straight	1
Scissors, bandage, angular, 7½"	2
Forceps, hemostatic, Rochester, curved, 6¼"	6
Forceps, hemostatic, Rochester, straight, 5½"	6
Forceps, tissue, spring, 5½"	1
Forceps, tissue, spring, mouse-tooth, 5½"	1
Forceps, tongue holding, 7"	1
Tube, breathing (airway) hard rubber or metal (adult)	1
Tube, breathing (airway) hard rubber or metal (child)	1
Retractor, tissue, double end nested 9" and 10" Army type, pair.....	1
Syringe, hypodermic, Luer, 2 cc.....	2
Needles, hypodermic, 25 gage, ½".....	12

Needles, hypodermic, 19 gage, 1½".....	6
Tubes, constriction (length 3") for needles.....	12
Stoppers, tube, constriction for needles.....	12
Handles, Bard Parker, No. 3.....	2
Blades, Bard Parker, No. 10, package of 6.....	1

SUTURE MATERIAL

Catgut, plain No. 1, tubes, boilable.....	6
Silk, dermal, medium, 40" strand, package of.....	6
Needles, suture, catgut, size 1, half-circle, trochar point, Mayo	6
Needles, cutting edge, straight.....	6

DRUGS

Morphine sulfate syrettes, 0.015 gm.....	20
Morphine sulfate syrettes, 0.030 gm.....	10
Sulfathiazole, powder, vials, 5 gm.....	12
Ointment, ophthalmic, boric acid, 5%, tube, 4 mg.....	1
Jelly, tannic acid, tube, 45 gm.....	2
Alcohol, denatured, ethyl, bottle, 500 cc.....	1
Ammonia, aromatic spirit, bottle, 60 cc.....	1
Sodium bicarbonate	½ lb.
Phenobarbital tablets, 0.03 gm	100
Caffeine sodium benzoate, ampules, 0.5 gm.....	12
Epinephrin hydrochloride, 1:1000	20 cc.

DRESSINGS AND BANDAGES

Compress, gauze, 4" x 4".....	100
Compress, gauze, 2" x 2".....	200
Pad, surgical, 8" x 10" (Dakin).....	25
Bandage, gauze, 2".....	24
Bandage, muslin, 4".....	24
Bandage, triangular, muslin, 50" x 36" x 36".....	24
Cotton, absorbent, roll, sterile.....	2 oz.
Cotton batting, roll.....	1 lb.
Plaster, adhesive, 2" x 10 yards, roll.....	2

MISCELLANEOUS SUPPLIES

Pins, safety, large.....	48
Splints, basswood.....	12
Depressors, tongue, wood.....	24
Applicators, wood.....	25
Sheeting, rubber (45" x 72").....	1
Basins, white enamel, 9" x 6" x 1⅞" (one with cover)	2
Stove, gasoline (Coleman).....	1
Pencil, inedible	1
Pencil, dermatographic (red).....	1
Pads, heating, chemical.....	4
Pads, heating, refills, chemical.....	4
Gloves, surgeon's, rubber, size No. 8 (latex), pair.....	2
Flashlight (two-cell)	1
Battery, dry cell, for flashlight, No. 950.....	4
Lantern, electric, dry-cell type.....	1
Battery, dry cell, for lantern, No. 6.....	4
Cups, paper	25
Brush, nail	1
Soap, hand, bar.....	2
Towels, hand	12
Matches, safety, box.....	3
Tourniquet, field, web.....	3
Bag, laundry, small.....	1
Tags, identification, book of 20.....	6
Casualty record book.....	1

b. List No. 2.—Equipment for a Casualty Station—(Supplementary supplies for an emergency squad of two or four physicians, nurses, and nursing auxiliaries.) List No. 2 indicates the medical and surgical equipment for a

Casualty Station. It contains bulky articles such as traction splints which could not be included in the equipment of the First-Aid Post without impairing its mobility. These articles will be issued from the Casualty Station to the First-Aid Posts as the need arises. Casualty Stations are also stocked with dressings, bandages, and drugs from which the supplies of the First-Aid Posts may be replenished. Blood, plasma, and other biological products as tetanus antitoxin or toxoid may be obtained by Casualty Stations from the parent hospital as needed. They are, therefore, omitted from this list.

Trunk, Army type..... 1

TRACTION SPLINTS

Splint, arm, hinge, Thomas..... 4
 Splint, leg, half-ring, Army type..... 4
 Splint, Thomas, leg, child..... 2
 Splint, arm, Murray Jones, child..... 2

SUTURE MATERIAL

Catgut, plain No. 1, tubes, boilable..... 12
 Silk, dermal, medium 40" strand, package of 12..... 1
 Needles, suture, size No. 1 half-circle, trochar point, Mayo..... 12
 Needles, cutting edge, straight..... 12

DRUGS

Morphine sulphate syrettes, 0.015 gm..... 40
 Morphine sulphate syrettes, 0.030 gm..... 20
 Sulfathiazole, powder, vials, 5 gm..... 24
 Ointment, boric acid, ophthalmic, 5%, tube, 4 gm..... 2
 Jelly, tannic acid, tube, 45 gm..... 4
 Alcohol, denatured, ethyl, 70%..... 1 qt.
 Ammonia aromatic spirit, bottle 60 cc..... 1
 Sodium bicarbonate..... 1 lb.
 Phenobarbital tablets, 0.03 gm..... 200
 Caffeine sodium benzoate ampoules, 0.5 gm..... 24
 Procaine hydrochloride tablets, 0.18 gm..... 100
 Sodium chloride compressed tablets, 1 gm..... 100

DRESSINGS AND BANDAGES

Compress, gauze, 4" x 4"..... 200
 Compress, gauze, 2" x 2"..... 400
 Pad, surgical, 8" x 10" (Dakin)..... 50
 Bandage, gauze, 2"..... 48
 Bandage, muslin, 4"..... 48
 Bandage, triangular, muslin (50" x 36" x 36")..... 48
 Cotton, absorbent, roll..... 1 lb.
 Cotton batting, roll..... 2 lb.
 Plaster, adhesive, 2" x 10 yards..... 4

MISCELLANEOUS SUPPLIES

Pins, safety, large..... 100
 Splints, basswood..... 30
 Depressors, tongue, wood..... 100
 Applicators, wood..... 50
 Sheeting, rubber (45" x 72")..... 2
 Basins, white enamel, 9" x 6" x 1 7/8" (2 with cover)..... 4
 Stove, gasoline (Coleman)..... 2
 Catheter, urethral, rubber, F14..... 4
 Pencil, indelible..... 4
 Pencil, dermatographic (red)..... 4
 Pads, heating, chemical..... 8
 Refills, pads, heating, chemical..... 8
 Gloves, surgeon's, rubber, size 8 (latex), pair..... 4
 Lantern, electric, dry cell..... 2
 Batteries, dry cell, lantern, No. 6..... 12
 Cups, paper..... 50
 Brush, nail..... 2

Soap, hand, bar..... 4
 Towels, hand..... 24
 Matches, safety, package of 12 boxes..... 1
 Tourniquet, field web..... 6
 Bag, laundry, small..... 2
 Tags, identification book (books of 20)..... 6
 Razor, safety..... 1
 Blades, safety razor..... 12

III. Identification Tags: The identification tag (Figure 1) is to be filled out by the first member of a Rescue Squad, Stretcher Team, or First-Aid Post to reach the casualty. This must be done immediately because the injured may lose consciousness. All the required information should be recorded. Information concerning the name and address of the injured and of the "person to be notified" are important to those anxious to locate the injured person. The place where an unconscious patient was found should be noted as this may be the only clue to his identity.

It is important to record administration of narcotics or application of a tourniquet. Further treatment given at the First-Aid Post or Casualty Station should be indicated on the back of the identification tag. Warnings concerning possible internal injury, hemorrhage, skull fracture, etc. should also be noted on the back of the tag to facilitate sorting of patients on arrival at the hospital.

The tag should be affixed securely to the patient and not to clothing which might later be removed.

A set of symbols to indicate necessity for priority treatment has been devised to facilitate sorting of patients at the hospital. These symbols should be drawn prominently on the forehead of the patient at the First-Aid Post or Casualty Station with a red skin pencil.

U=Urgent—requiring priority attention.

TK=Tourniquet.

T=Indicating tetanus antitoxin has been given.

H=Internal hemorrhage.

M 1/4=Indicating morphine gr. 1/4 or

M 1/2=gr. 1/2 given.

In addition to the identification tag, a Casualty Record Book will also be part of the equipment of each physician's team (Figure 2). A nurse or nurses aide should be assigned the responsibility for entering a record of every patient seen. This record should include the diagnosis, treatment, and disposition.

IV. Emergency Medical Services: It is important that each local Defense Council in the States along both sea-boards and in industrial centers in the interior appoint without delay a Chief of Emergency Medical Service who will be responsible to the local Director of Civilian Defense for the organization of the Emergency Medical Service described in Medical Division Bulletin No. 1. He should be an outstanding medical leader, and it is advisable that he be selected in consultation with the State Defense Council, the local medical society, and the local health officer. To facilitate the integration of all local medical resources into a comprehensive program for civilian protection, it is recommended that the local Chief of Emergency Medical Service be assisted by a Medical Advisory Council, consisting of the local health officer, an experienced hospital executive, and representatives of the local medical society, the nursing profession, the American Red Cross, and participating voluntary agencies.

a. Duties of the Local Chief of Emergency Medical Service—Under the administrative authority of the local Director of Civilian Defense, the duties of the local Chief of Emergency Medical Services (EMS) are:

1. To determine the scope of the activities of all official

and voluntary organizations which are to participate in the emergency medical program of civilian defense, to integrate these organizations into the comprehensive local program, and to assist them in expanding their activities to the limit of their resources in personnel and equipment.

2. To assist hospitals in the locality to organize, equip, and train Emergency Medical Field Units as outlined in Medical Division Bulletin No. 1, "Emergency Medical Service for Civilian Defense."

3. To inspect and select sites for the establishment of Casualty Stations.

4. To make a spot map of the locality, indicating the locations of hospitals, appropriate sites for Casualty Stations, and depots for storage of stretchers, collapsible cots, and blankets. The map should indicate the number of Emergency Medical Squads in each hospital. Copies of the map should be supplied to Control Centers, Police and Fire Departments, Health Department, local Red Cross Chapter, State Defense Council, Regional Director, Regional Medical Officer, and all cooperating hospitals.

5. To plan and establish adequate transportation service for casualties and medical personnel in consultation with local government departments, American Red Cross, and voluntary agencies.

6. To arrange with the local defense authority for field drills of Emergency Medical Units in collaboration with police and fire auxiliaries, disaster relief and canteen services of the American Red Cross, ambulance transport service, and other civilian defense units.

7. To make an inventory of hospital facilities in the locality and of the possibilities for their emergency expansion in bed capacity.

8. To assist the authorities charged with preparing plans for evacuation in making an inventory of hospitals, convalescent homes, sanatoria, hotels, and other structures within a radius of fifty to one hundred miles which might be used as base hospitals to which patients in city institutions could be evacuated.

9. To assist the local volunteer office in establishing courses for volunteers in the fields of health, medical care, nursing, and related activities.

10. To stimulate recruitment of volunteers for Nurses' Aide courses of the American Red Cross, assist the local Red Cross chapter in establishing Training Centers for Volunteer Nurses' Aides at appropriate hospitals, and assist the Red Cross in placing Nurses' Aides with hospitals, clinics, health departments, and field nursing services after completion of training.

11. To assist the local Civilian Defense Volunteer Office in training and placing other volunteers in health and medical agencies in the community.

12. To stimulate and guide extension of first-aid training by qualified Red Cross instructors as widely as possible among the local population.

13. To stimulate and guide industrial plants, business establishments, and Government bureaus in the locality in the training and organization of effective first-aid detachments among the employees.

14. To collaborate with State and local health departments and through them with the Regional Sanitary Engineer in a comprehensive program for the protection of the community against emergency sanitary hazards.

15. To collaborate with local and State Defense Councils, Office of Civilian Defense, Federal Security Agency, Children's Bureau, and other local, State, and Federal authorities in the preparation of plans for evacuation, with particular attention to the medical needs of the population

under such circumstances.

16. To keep the community and particularly the members of the health and medical professions and the participating official and voluntary organizations informed of the plans and activities of the local Emergency Medical Service."

MINUTES

The following are the minutes of a meeting of the Committee on Medical Preparedness which was held in Topeka on January 5:

Members of the committee present were: Dr. C. D. Blake, Chairman of Hays; Dr. H. N. Tihen of Wichita, Dr. Seth A. Hammell of Topeka, Dr. W. M. Mills of Topeka, Dr. C. C. Nesselrode of Kansas City, and Dr. F. L. Loveland of Topeka. Other members present were: Dr. Marion Trueheart of Sterling, Dr. A. J. Revell of Pittsburg, Mr. Clarence G. Munns was present as Executive Secretary.

Dr. Blake described the appointment of Dr. Loveland on the Seventh Corps Area Committee for Procurement and Assignment of Physicians, and asked Dr. Loveland to comment on any information he cared to present in that regard. Dr. Loveland stated that as yet no detailed information has been received concerning the work of this committee.

Dr. Hammel presented information concerning medical needs and assistance in the Selective Service program and also a report as to the plans which have been made for the deferment of medical students.

Clarence Munns presented a report as to the number of physicians from the various states which have entered military service. This information showed that approximately five per cent of the licensed doctors of medicine in Kansas are now engaged in military duty and that this percentage averages favorably with the other states. Credit for the assembly of this data was given the Indiana State Medical Association, inasmuch as it commenced a survey of this information in advance of a similar survey planned by this committee and as the Indiana State Medical Association was kind enough to forward the Society a copy of its findings.

The next item of discussion pertained to the questionnaire, in regard to physician volunteers for military duty, recently issued by the Procurement and Assignment Service in Washington.

Upon a motion made by Dr. Mills, seconded and carried, it was suggested that the Council should hold a meeting as soon as additional information is available concerning the plans of the Army and Navy for the procurement of physicians; that the Councilors be asked at that meeting to hold district meetings for the purpose of acquainting the membership with the needs for their services; and that if possible the meeting of the Council be held in the near future.

The next item of discussion pertained to plans for civilian defense activities. Dr. Loveland commented on the needs which will exist for communities to have as complete medical services as is possible during the war and of his hope that arrangements can be made to coincide this matter with the selection of physicians who will be accepted for military duty. A suggested bulletin on this subject was read, and release of same to the county medical societies and the official representatives was authorized under the signature of the committee.

In a discussion of additional ways in which the Society can assist the operation of the Selective Service program,

Colonel Hammel reported that the new plan for physical examination of Selective Service registrants is now operating in all counties in the State and that satisfactory help is being received from physicians and county medical societies. Colonel Hammel also reported that study is being made in Washington of a program for rehabilitation treatment of rejected Selective Service registrants.

Adjournment followed.

COUNTY SOCIETIES

At a recent meeting of the Atchison County Medical Society the following new officers were elected: Dr. W. L. Anderson of Atchison as President; Dr. E. T. Wulff of Atchison as Vice-President; Dr. Frank K. Bosse of Atchison as Secretary-Treasurer; Dr. W. K. Fast of Atchison as a member of the Board of Censors, and Dr. Hugh L. Charles of Atchison as Delegate.

The Brown County Medical Society held a meeting on January 9 in Moreland. Dr. J. W. Randall of Marysville and Dr. R. T. Nichols of Hiawatha were the speakers.

The Clay County Medical Society was host to the members of the Seventh Councilor District and their wives, at a meeting held in Clay Center on January 14. The speakers on the program were: Dr. C. D. Blake of Hays, Lt. Col. Seth A. Hammel of Topeka, Dr. W. M. Mills of Topeka and Dr. F. L. Loveland of Topeka. The speakers discussed various aspects of medical preparedness. Dr. Raymond Gelvin of Concordia showed motion pictures of trips to Arkansas and Canada.

The Coffey County Medical Society elected the following officers at a meeting held in Burlington on January 13: Dr. A. N. Gray of Burlington as President and Dr. M. W. Wells of LeRoy as Secretary.

The Cowley County Medical Society held a dinner meeting in Winfield on January 22 at which the wives of the members were guests.

A meeting of the members residing within the Eleventh Councilor District was held in Kinsley on February 13, with the Edwards County Medical Society as hosts. A business meeting was held following the dinner. Dr. G. O. Speirs, Councilor of the Twelfth District was a guest and advisor. Resolutions of the meeting were submitted to the Executive Secretary of the Society. A permanent society of the district was organized and the following officers were elected: Dr. Herbert Atkins of Pratt as President; Dr. L. A. Latimer of Alexander as Vice-President, and Dr. F. E. Dargatz of Kinsley as Secretary-Treasurer. Nineteen physicians from all parts of the district were present.

The following officers were elected at a recent meeting of the Ford County Medical Society: Dr. C. R. McCarty of Dodge City as President, Dr. D. R. Davis of Dodge City as Secretary, and Dr. V. B. Dowler of Dodge City as Treasurer.

The Johnson County Medical Society met in Olathe on January 5. Dean H. R. Wahl of Kansas City spoke on "The History of the University Hospitals." Officers elected at the meeting to serve during the rest of the year were: Dr. R. L. Moberly of Olathe as President, Dr. H. S. Albaugh of Olathe as Vice-President, and Dr. J. A. Knoop of Olathe as Secretary-Treasurer.

The Linn County Medical Society held a meeting in Mound City on January 5. The following new officers were elected: Dr. J. T. Kennedy of Blue Mound as President, Dr. S. D. Morris of La Cygne as Vice-President, and Dr. H. L. Clark of La Cygne as Secretary-Treasurer.

The February meeting of the Lyon County Medical Society was held in Emporia. Dr. J. J. Hovorka of Emporia spoke on "Malignancies of the Thyroid." In addition to the officers who were elected at the December meeting of the society and announced in a previous issue of the Journal, Dr. C. E. Partridge of Emporia and Dr. Frank Fonnannon of Emporia were elected as Delegates and Dr. D. R. Davis of Emporia and Dr. C. W. Lawrence of Emporia as Alternates.

The Marion County Medical Society entertained the wives of its members at a dinner meeting held in Marion on February 4. Motion pictures on surgery and on travel were shown.

The Neosho County Medical Society elected its officers for the year at a meeting held in Chanute on January 3. Dr. R. A. Light of Chanute was elected as President, Dr. James A. Butin of Chanute as Secretary-Treasurer, and Dr. Herbert Rollow of Chanute as Delegate.

The Pratt County Medical Society held a meeting on January 23 in Pratt. Dr. Fred McEwin of Wichita spoke on "Management of Cardiac Emergencies" and Dr. Anthony Rossitto of Wichita spoke on "Therapeutic X-Ray in Sinus Infection and Asthma."

At a meeting of the Riley County Medical Society held in Manhattan on December 17, Dr. C. R. Kempthorne of Manhattan was elected as President of the society, Dr. J. D. Colt, Jr. of Manhattan as Vice-President; Dr. Ruth Montgomery of Manhattan as Secretary-Treasurer and Dr. Ralph Ball as a member of the Board of Censors. Mr. George Lerrigo of Topeka, a member of the staff of the Kansas State Board of Health, spoke on "Rehabilitation of Selective Service Registrants".

The Rush-Ness County Medical Society met in Ness City on February 11. The following were elected to office for this year: Dr. N. W. Robison of Bison as President, Dr. J. E. Attwood of LaCrosse as Secretary, Dr. L. A. Latimer of Alexander as Delegate, and Dr. W. J. Singleton of LaCrosse as Alternate.

The February 3 meeting of the Sedgwick County Medical Society was held in Wichita. Dr. James A. Wheeler of Newton and Dr. Lee Roderick of the Kansas State College of Manhattan spoke on "Epidemiology of Encephalitis."

The Washington County Medical Society held a meeting in Washington on January 13. Dr. Z. H. Snyder of Greenleaf spoke on "Diagnosis and Treatment of Poliomyelitis."

The Wyandotte County Medical Society met in Kansas City on January 20. Speakers were: Dr. W. H. Algie of Kansas City who discussed "Pneumonia," and Dr. P. M. Krall of Kansas City who spoke on "The Sulfa Compounds in Therapeutics." At another meeting held on February 3, Dr. John Bowser of Kansas City discussed the "Roentgenological Demonstrable Causes Cynosis in Infants," and Dr. H. M. Day of Kansas City who spoke on "Trichinosis."

MEMBERS

The article on "Problems in the Therapy of Intractable Asthma" by Dr. Archibald J. Brier of Topeka, which was published in the December issue of the Journal, was abstracted in the January issue of Southern Medicine and Surgery.

Dr. D. V. Conwell, formerly of the Hertzler Clinic in Halstead, is now located in Wichita.

Dr. August P. Fleckenstein, formerly of Herndon, is now located in Oberlin.

Dr. H. L. Regier of Kansas City attended the Congress on Industrial Health held in Chicago, Illinois, on January 12-13.

Dr. Ernest M. Seydell of Wichita is the author of an article entitled "Relation of Tonsillectomy to Poliomyelitis" which was published in the January, 1942, issue of Archives of Otolaryngology.

Dr. J. W. Spearing, formerly of Columbus, is now director of medical service of the Ordnance Plant at Parsons.

Dr. C. B. Stephens, formerly of Topeka, is now a member of the staff of the Osawatomie State Hospital.

"Undulant Fever," an article by Dr. Ragnar T. Westman of Kansas City, which was published in the November, 1941, issue of the Journal, was abstracted in the January, 1942, issue of The Ohio State Medical Journal.

An abstract of the article, "Management of Menopausal Syndrome with Stilbestrol" by Dr. Louis K. Zimmer of Lawrence, published in the August issue of the Journal, was reprinted in the January, 1942, issue of Digest of Treatment.

Announcement has been made of the appointment of Dr. A. K. Owen of Topeka as counselor of the American College of Radiology for Kansas.

Dr. Milton Lozoff of Topeka, Dr. V. B. Kenyon of Osawatomie, and Mr. David Rapaport of Topeka were the

authors of an article on "Metrazol Convulsion in the Treatment of the Psychosis of Dememtia Paralytica" which was published in the November issue of Archives of Neurology and Psychiatry.

DEATH NOTICES

Dr. Fred H. Bell, 60 years of age, died at his home in Baldwin in January. Dr. Bell was born in Flora, Illinois, on September 9, 1881. He was graduated from the University Medical College of Kansas City in 1905. He was a member of the Douglas County Medical Society.

Dr. Walter Raleigh Breeding, 77 years of age, died on January 9 at his home in Marysville. He was born on September 30, 1864, in Bloomington, a now-extinct town south of Lawrence. He was graduated from the Rush Medical College in 1892. He was one of the organizers of the Marshall County Medical Society.

Dr. Joseph Edward Hawkey, 90 years of age, died of hypostatic pneumonia on February 11 in Burr Oak. Dr. Hawkey was graduated from the St. Joseph Hospital Medical School of St. Joseph, Missouri, in 1882. He is the last surviving charter member of the Jewell County Medical Society of which he has been president for the past twenty-five years.

ANNOUNCEMENTS

The Fifth American Psychiatric Association Postgraduate Institute will be held in St. Joseph, Missouri, on March 25 to April 4. Additional information on the meeting may be secured by writing to Dr. Franklin G. Ebaugh, Colorado Psychopathic Hospital, Denver, Colorado.

Due to the War the Thirty-second Annual Clinical Congress of the American College of Surgeons will be held in Chicago on October 19-23 instead of in Los Angeles as originally planned. The Twenty-fifth Annual Hospital Standardization Conference sponsored by the College will be held simultaneously. The program of both meetings will be based chiefly on wartime activities as they effect surgeons and hospital personnel in military and civilian service.

The American Association for the Study of Goiter again offers the Van Meter Prize Award of three hundred dollars and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The award will be made at the annual meeting of the Association which will be held at Atlanta, Georgia, on June 1-3, providing essays of sufficient merit are presented in competition. The competing essays may cover either clinical or research investigations; should not exceed three thousand words in length; must be presented in English; and a typewritten double-spaced copy sent to the Corresponding Secretary, Dr. T. C. Davidson, 478 Peachtree Street, Atlanta, Georgia, not later than April 1.

BOOK NOOK

BOOK REVIEWS

ESSENTIALS OF GENERAL SURGERY—Wallace P. Richie, M.D. Published by the C. V. Mosby Company of St. Louis, Missouri. Priced at \$8.50. The reviewer receives the impression that lecture notes have been utilized and somewhat amplified in the composition of material for the volume. As undergraduate medical students are not taught surgical technique there is no effort made to go into the technical application of operative surgery. The book deserves commendation as a well organized presentation of elementary principles such as a preliminary survey course may be expected to cover.—R.B.S.

ABDOMINAL SURGERY OF INFANCY AND CHILDHOOD—William E. Ladd, M.D., F.A.C.S., and Robert E. Gross, M.D. W. B. Saunders Company, of Philadelphia, Pennsylvania. It has long been recognized by general surgeons themselves that operative therapeutics when applied to certain groups of cases, should require the approach of surgeons trained first in the special field and then in the operative technique particularly designed for the specialty. At the turn of the century men who were devoting their attention to orthopedics were limiting their surgery to manipulations, while the actual surgery was being done by general surgeons. The orthopedic men finally got around to training their own surgeons. There was little advance in orthopedic surgery, or in neurological surgery until surgeons were trained within these specialties. The same is true of urology, obstetrics, and gynecology. The book under discussion is the outcome of the same evolutionary process in the field of pediatrics. Dr. James B. Stone of Boston, realizing that a special technique should be developed in the abdominal surgery of infants and children, first began to develop this field about twenty-five years ago and it has since been carried on by the staff of The Boston Children's Hospital. That this work should be published is due to a liberal grant from the Godfrey M. Hyams Trust Fund. The book is to be commended for its thoroughness and scope of abdominal conditions requiring surgical treatment and for the details of the preoperative and postoperative care, a knowledge of which is so essential to the successful management of surgical patients in this early age group.—R.B.S.

MANUAL OF CLINICAL CHEMISTRY—Miriam Reiner, M.Sc., Assistant Chemist to the Mount Sinai Hospital of New York, and introduction by Harry Sobotka, Ph.D., Chemist to the Mount Sinai Hospital, New York. Published by the Interscience Publishers, Inc. of New York, this little book of 296 pages contains a valuable fund of information and a splendid guide for the interne as well as the laboratory technician. Compiled primarily to assist the interne in emergency laboratory procedures, it has been expanded to include besides laboratory technique, vitamin functions and clinical tests, excluding the usual text book information. It includes some of the more frequently used tables and standardization of solutions. A splendid manual to own.

BOOKS RECEIVED

CANCER OF THE FACE AND MOUTH, Diagnosis, Treatment, Surgical Repair—Vilray P. Blair, M.D., Sherwood Moore, M.D., and Louis T. Byars, M.D., of St. Louis, Missouri. Published by the C. V. Mosby Company of St. Louis, the book contains 599 pages, illustrated and is priced at \$10.00.

HEALTH RESORTS OF THE U.S.S.R., A Symposium of Articles Compiled from Data of the Central Institute of Balneology in Moscow, Edited by Dr. I. A. Pertsov. Published by the Union of Soviet Socialist Republics, under the supervision of the Society of Cultural Relations with Foreign Countries.

THE ESSENTIALS OF APPLIED MEDICAL LABORATORY TECHNIC, Details of How to Build and Conduct and office or Small Hospital Laboratory at Small Cost—I. M. Feder, M.D., Director of Laboratories and Allergic Service, Anderson County Hospital, Anderson, South Carolina, and Blood and Plasma Transfusion, by John Elliott, Sc.D., Pathologist Rowan General Hospital, Salisbury, North Carolina. Published by the Charlotte Medical Press, Charlotte, North Carolina, 1940.

CARDIAC CLASSICS—Frederick A. Williams, M.D., and Thomas E. Keys, A.B. The book, which contains fifty-two contributions by fifty-one authors, is published by the C. V. Mosby Company of St. Louis, Missouri, contains 858 pages and is illustrated.

BODY MECHANICS IN HEALTH AND DISEASE—Joel E. Goldthwait, M.D., Lloyd T. Brown, M.D., Loring T. Swaim, M.D., John G. Kuhns, M.D., and William J. Kerr, M.D. Third Edition. Published by the J. B. Lippincott Company of Philadelphia, Pennsylvania. The book contains 316 pages, 121 illustrations and is priced at \$5.00.

ESSENTIALS OF ENDOCRINOLOGY—Arthur Grollman, Ph.D., M.D., Associate Professor of Pharmacology and Experimental Therapeutics in the Medical School of the Johns Hopkins University; formerly Associate Professor of Physiology and Instructor in Chemistry in the same institution. Published by the J. B. Lippincott Company, Philadelphia, Pa. Contains 480 pages and seventy-four illustrations.

THE THERAPY OF THE NEUROSES AND PSYCHOSES, A Socio-Psycho-Biologic Analysis and Resynthesis—Samuel Henry Kraines, M.D., Associate in Psychiatry, University of Illinois, College of Medicine; Assistant State Alienist, State of Illinois; Diplomate of American Board of Psychiatry and Neurology. Published by Lea & Febiger, Philadelphia, 1941. Priced at \$5.50. Contains 512 pages. Subtitles are as follows: Classification of the Psychiatric States; The Fundamental Psychology of the Psychoneuroses; Psychoneurotic Symptoms Expressed Primarily by Psychologic Factors; Psychoneurotic (Tension) Symptoms Due to Disturbances in the Autonomic Nervous System; Sex Drives; The Principles of Psychotherapy; Technique of Analysis of Personality Difficulties; Stress as a Determining Factor; Retraining Attitudes and Reaction Patterns; Characteristic General Attitudes and Their Treatment; Adjuvant Therapy-Suggestion, Hypnosis, and Drugs;

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***The Military Surgeon*, Vol. 89, No. 1, p. 7, July, 1941

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NECROPSY—Bela Halpert, M.D., Assistant Professor of Pathology and Bacteriology of the Louisiana State University School of Medicine and visiting Pathologist to the Charity Hospital of Louisiana at New Orleans, Louisiana. Published by the C. V. Mosby Company of St. Louis, Missouri, the book is priced at \$1.50.

A MANUAL OF BANDAGING, STRAPPING AND SPLINTING—August Thorndike, Jr., M.D., Associate in Surgery of the Harvard Medical School. Published by Lea and Febiger of Philadelphia, Pennsylvania. The book contains 144 pages, 117 illustrations and is priced at \$1.50.

ANNUAL REPRINT OF THE REPORTS OF THE COUNCIL ON PHARMACY AND CHEMISTRY OF THE AMERICAN MEDICAL ASSOCIATION FOR 1940—Published by the American Medical Association, 535 North Dearborn Street, Chicago, Illinois.

THE CARE OF THE AGED (GERIATRICS)—Malford W. Thewlis, M.D., Attending Specialist, General Medicine, of the United States Public Health Hospitals of New York City. Third Edition. Published by the C. V. Mosby Company of St. Louis, Missouri; contains 579 pages and fifty illustrations.

DISEASES OF THE THYROID GLAND—Arthur E. Hertzler, M.D. Published by Paul B. Hoeber, Inc. Medical Book Department of Harper & Brothers of New York, the book contains 670 pages, illustrated and is priced at \$8.50.

NEW AND NONOFFICIAL REMEDIES, 1941—Published by the American Medical Association, 535 North Dearborn Street, Chicago, Illinois. Articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association for 1941.

CARDIAC CLINICS, A Mayo Clinical Monograph—Frederick A. Willius, M.D., head of the section of Cardiology, Mayo Clinic and Professor of Medicine, Mayo Foundation for Medical Education and Research Graduate School, University of Minnesota, Rochester, Minnesota. Publish by the C. V. Mosby Company of St. Louis, Missouri. The book contains 276 pages, illustrated and is priced at \$4.00.

SYNOPSIS OF APPLIED PATHOLOGICAL CHEMISTRY—Jerome E. Andes, M.D., Director of the Department of Health and Medical Advisor of the University of Arizona, Tuscon, and A. G. Eaton, B.S., Assistant Professor of Physiology of Louisiana State University School of Medicine of New Orleans. Published by the C. V. Mosby Company of St. Louis, Missouri, with 428 pages, twenty-three illustrations, priced at \$4.00.

MICROBES WHICH HELP OR DESTROY US—Paul W. Allen, Ph.D., D. Frank Holtman, Ph.D., and Louis Allen McBee, M.S. Published by the C. V. Mosby Company of St. Louis, Missouri. Priced at \$3.50.

HANDBOOK OF COMMUNICABLE DISEASES—Franklin H. Top, M.D., Director of the Division of Communicable Diseases and Epidemiology, Detroit Department of Health. Published by the C. V. Mosby Company of St. Louis, Missouri. Priced at \$7.50.

THE TREATMENT OF INFANTILE PARALYSIS IN THE ACUTE STATE—Elizabeth Kenny. Published by the Bruce Publishing Company of Minneapolis and Saint Paul, Minnesota. Priced at \$3.50, the book contains 285 pages of well illustrated material.

INFANT NUTRITION, A Textbook of Infant Feeding for Students and Practitioners of Medicine—William McKim Marriott, B.S., M.D., and revised by P. C. Jeans, A.B., M.D., Professor of Pediatrics, College of Medicine of the State University of Iowa, Iowa City. Published by the C. V. Mosby Company of St. Louis and priced at \$5.50. The book contains 475 pages. Third Edition.

DISEASES OF WOMEN—Harry Sturgeon Crossen, M.D., F.A.C.S., Professor of Clinical Gynecology of the Washington University School of Medicine and Gynecologist to the Barnes Hospital of St. Louis, and Robert James Crossen, A.B., M.D., Assistant Professor of Clinical Gynecology and Obstetrics of Washington University School of Medicine and Assistant Gynecologist and Obstetrician to the Barnes Hospital of St. Louis. Published by the C. V. Mosby Company of St. Louis. Ninth Edition, entirely revised and reset. The book contains many hundreds of engravings, 948 pages and is priced at \$12.50.

FOOD AND BEVERAGE ANALYSES—Milton Arlenden Bridges, B.S., M.D., F.A.C.P., late Assistant Clinical Professor of Medicine and Lecturer in Therapeutics, New York Post-Graduate Medical School, Columbia University and Marjorie R. Mattice, A.B., M.S., Assistant Professor of Pathological Chemistry, Department of Medicine, New York Post-Graduate Medical School, Columbia University; Chief Chemist, New York Post-Graduate Hospital, Consultant Chemist, Department of Correction Hospital, City of New York. Second Edition revised and enlarged. Published by the Lea and Febiger Publishers of Philadelphia, Pennsylvania. Priced at \$4.00. The volume contains 344 pages.

TREATMENT OF THE PATIENT PAST FIFTY—Ernest P. Boas, M.D., Associate Physician, Mount Sinai Hospital, New York City, Chairman of the Committee on Chronic Illness, Welfare Council of New York City, Assistant Clinical Professor of Medicine, Columbia University. Published by The Year Book Publishers, Inc., Chicago, Illinois. Priced at \$4.00.

THE 1941 YEAR BOOK OF GENERAL SURGERY—Edited by Evarts S. Graham, A.B., M.D., Professor of Surgery, Washington University School of Medicine, Surgeon-in-Chief of the Barnes Hospital and the Children's Hospital of St. Louis, Missouri. Published by The Year Book Publishers, Inc., Chicago, Illinois. Priced at \$3.00.

THE 1941 YEAR BOOK OF OBSTETRICS AND GYNECOLOGY—Obstetrics by Joseph B. DeLee, A.M., M.D., Professor of Obstetrics, University of Chicago Medical School; Chief of Obstetrics, Chicago Lying-in Hospital

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SYNOPSIS OF GENITOURINARY DISEASES—Austin I. Dodson, M.D., F.A.C.S., Professor of Genitourinary Surgery, Medical College of Virginia; Genitourinary Surgeon to Crippled Children's Hospital; Urologist to St. Elizabeth's Hospital; Urologist to St. Luke's Hospital and McGuire Clinic. Third Edition, published by the C. V. Mosby Company of St. Louis, Missouri. Priced at \$3.50, this book contains 302 pages and 112 illustrations.

LABORATORY DIAGNOSIS OF PROTOZOAN DISEASES—Charles Franklin Craig, M.D., Emeritus Professor of Tropical Medicine in The Tulane University of Louisiana, New Orleans, Louisiana. Published by Lea & Febiger of Philadelphia, Pennsylvania. The book is priced at \$4.50, contains 349 pages, with fifty-four illustrations and four color plates.

THE NEW INTERNATIONAL CLINICS, Volume IV, New Series Four, 1941. Published by the J. B. Lippincott Company of Philadelphia, Pennsylvania.

ENCEPHALITIS, A Clinical Study—Josephine B. Neal, A. B., M.D., Sc.D., F.A.C.P., Associate Director of the Bureau of Laboratories, Department of Health of New York; Clinical Professor of Neurology, College of Physicians and Surgeons of Columbia University, New York, and Collaborators. Published by Grune & Stratton of New York, 1942.

THE TOXEMIAS OF PREGNANCY—William J. Dieckmann, M.D., Associate Professor of Obstetrics and Gynecology, The University of Chicago; Attending Obstetrician The Chicago Lying-in Hospital and Dispensary; Attending Gynecologist, Albert Merrit Billings Memorial Hospital and the University of Chicago; Associate Editor of the American Journal of Obstetrics and Gynecology; Co-chairman of the Conference of Eclampsia, United States Department of Labor of the Children's Bureau. Published

by the C. V. Mosby Company of St. Louis, Missouri. Priced at \$7.50. The volume contains 321 pages, fifty illustrations and three color plates.

A TEXT-BOOK OF NEURO-ANATOMY—Albert Kuntz, Ph.D., M.D., Professor of Micro-Anatomy in St. Louis University School of Medicine at St. Louis, Missouri. Published by Lea & Febiger of Philadelphia, Pennsylvania. Priced at \$6.00, this third revised edition contains 518 pages and 307 illustrations.

THE MARCH OF MEDICINE—New York Academy of Medicine Lectures to the Laity, 1941—Published by the Columbia University Press, New York, 1941. Priced at \$2.00.

IMMUNOLOGY—Noble Pierce Sherwood, Ph.D., M.D., F.A.C.P., Professor of Bacteriology, University of Kansas and Pathologist to the Lawrence Memorial Hospital, Lawrence, Kansas. Published by the C. V. Mosby Company of St. Louis, Missouri, 1941. The book is priced at \$6.50, and in its second edition, contains 639 pages, illustrated.

SYNOPSIS OF ALLERGY—Harry L. Alexander, A.B., M.D., Professor of Clinical Medicine, Washington University School of Medicine, St. Louis, and editor of the Journal of Allergy. Published by the C. V. Mosby Company, St. Louis, Missouri, 1941. Priced at \$3.00, the book contains 246 pages, illustrated.

THE 1941 YEAR BOOK OF PEDIATRICS—Edited by Isaac A. Abt, D.Sc., M.D., Professor of Pediatrics, Northwestern University Medical School; Attending Physician, Passavant Hospital; Consulting Physician, Children's Memorial Hospital and St. Luke's Hospital, Chicago, with the collaboration of Arthur F. Abt, B.S., M.D., Assistant Professor of Pediatrics, Northwestern University Medical School, Associate Attending Pediatrician, Michael Reese Hospital; Attending Pediatrician, Chicago Maternity Center; Attending Physician, Spaulding School for Crippled Children and La Rabida Jackson Park Sanatorium, Chicago. Published by the Year Book Publishers, Inc., of Chicago, the book is priced at \$3.00.

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THE 1942 YEAR BOOK OF GENERAL THERAPEUTICS—Oscar W. Betha, Ph.M., M.D., F.A.C.P., Professor of Clinical Medicine, Tulane University School of Medicine, Senior of Medicine, South Baptist Hospital, Senior Visiting Physician, Charity Hospital; member of the Revision Committee of the United States Pharmacopeia, 1930-1940; author of Clinical Medicine and Materia Medica, Drug Administration and Prescription Writing. Published by The Year Book Publishers, Chicago. Priced at \$3.00.

Hospitals are more appreciated today than ever before, doubtless because the Nation, in mobilizing its resources for defense, has recognized the fundamental value of a high average of health.—Irvin Abell, M.D., Hospitals, Journal of the American Hospital Association.

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KANSAS MEDICAL ASSISTANTS

Mrs. Vera Mathews of Kansas City, President of the Kansas Medical Assistants Society, recently announced the following appointments: Miss Irene Miller of Emporia as Chairman of the Emblem Committee, and Mrs. Edna Nichols of Hutchinson as Chairman of the Creed Committee. A request has also been made that each local association submit suggested creeds to the Creed Committee. These may be forwarded to Mrs. Nichols at 710 Wolcott Building, in Hutchinson.

The Atchison County Medical Assistants Society held a meeting in Atchison on January 5. Mr. Ray W. Gee of Kansas City showed a movie on "New Anaesthesia."

The Cowley County Medical Assistants Society met in Winfield on January 23. Mr. David Hall, of Arkansas City, president of the Kansas Junior Chamber of Commerce, spoke on "Civilian Defense." Mrs. Francis Anderson was elected as Secretary of the society to fill the unexpired term of Mrs. Margaret Rollo who recently resigned.

The Lyon County Medical Assistants Society held a meeting in Emporia on January 6. Miss Clair K. Turner of the Health Service Department of the Kansas State Teachers College, spoke on "First Aid in Civilian Defense" and Judge Joe Ralston of Emporia spoke on "Local Defense Programs." At the February 3 meeting of the society Dr. Frank Foncannon of Emporia showed travel movies of the United States and Canada.

The Riley County Medical Assistants Society met in

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Manhattan on February 3. Dr. J. D. Colt, Jr., spoke on "The Progress of Surgery."

The Reno County Medical Assistants Society met on January 13 in Hutchinson. Miss Audris Rife, dietician at the Grace Hospital was the speaker. At the February 10 meeting the society was entertained with a fashion show of uniforms.

The Sedgwick County Medical Assistants Society held a meeting on January 21 in Wichita. Mr. Stanley Spurrier discussed "Preparation of Income Tax Returns."

The Shawnee County Medical Assistants Society, formerly the Topeka Physicians Assistants Society, held its February 2 meeting in Topeka. Mr. Joe Schneider of Topeka, representative of the Eli Lilly Company, spoke on "The Physicians Assistant as Observed by the Contact Man." At the January 5 meeting of the society Mr. A. R. Jones of the firm of Brelsford, Gifford and Jones, accountants and auditors of Topeka, spoke on the preparation of income tax reports.

At the January meeting of the Wyandotte County Medical Assistants Society held in Kansas City, Mrs. Hylon Harmon, first hostess employed by Transcontinental and Western Airlines, discussed interesting experiences she had during her four and a half years of flying with the airline.

COMMENT

The following comment in regard to the paper presented by Mrs. Marjorie Euler, assistant to Dr. W. M. Mills of Topeka, at a meeting of the Michigan State Medical Society, was made by the Pennsylvania Medical Journal:

"In the September issue of the Michigan State Medical Society's Journal appears an interesting and instructive article by Mrs. Marjorie Euler of Topeka, Kansas, on 'The High Lights of Twenty-five Years of Service.' It is an intelligent and thoughtful survey of the rules of behavior for a doctor's assistant or his secretary and office nurse.

Mrs. Euler says that a girl who works for a doctor today 'is required to take medical dictation, write case and operative histories, keep accurate files, handle the doctor's correspondence, as well as to act as hostess, nurse, mother, entertainer, telephone operator, bookkeeper, collector, treasurer, income tax computer, and housekeeper'."

In regard to personal appearance, she says, 'You should be neat and well groomed at all times; your uniform and shoes should be kept spotless; make-up—yes, we should be as attractive as possible since we are the first glimpse that the public gets of the office; the nails should be well manicured with preferably a light or natural shade of polish.' She points out that one should always be five minutes early at the office, so that the doctor will never be annoyed by having a patient call him at home saying, 'I called your office, but no one answered.'

Under 'office housekeeping': 'We must dust first, as everything around a doctor's office should be kept as spotless as soap, water, and furniture polish can make it; magazines should be arranged neatly on tables, one at each end of the room if possible, so that patients will not have to reach across each other to get a magazine, as this is always annoying, especially if one does not feel well. Do by all means keep the magazines up to date. I think two of the so-called woman's magazines are nice, also a fashion magazine, as there is not a woman living, young or old, who is not interested in fashions. Then for those who have only a few minutes to wait, picture magazines; Hygeia will always have a big following.'

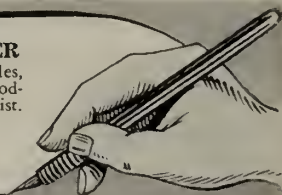
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Mrs. Euler seems to have a real grasp on the psychology of handling patients. She suggests, 'Before the patients start coming in I find that it helps to have a list of the appointments on your desk as well as the doctor's. Look these over until you are quite familiar with them, as nothing pleases a patient more than being addressed by his own name as he enters. If he is a new patient, be very careful about getting his name (spelled correctly), address, and telephone number. If married, get husband's initials and his place of employment; if a minor child, get father's initials. Do not leave this job up to the doctor, as he is often too busy or else he knows the patient well enough that he hesitates to ask for the rest of the information needed to keep good records.

'Usher patients in as near their appointments as possible, trying not to show any fuss or rush, regardless of how many are waiting. . . . A pleasant smile and ready welcome are a receptionist's best weapon in handling any patient. Learn to handle them she must, and each one differently. If the doctor is late getting in for his first appointment, even though you know he is lunching with his best crony, telling about the big one that got away, . . . above all things do not let the patient be aware of the fact that he is taking a few minutes to relax. My pet expression is, 'Doctor has had an extra busy morning at the hospital,' or 'We have had an emergency and the doctor is going to be a little late.' You'll find if you ask your patients to help you, they will co-operate nicely.'

The office assistant is advised to 'be nice to the medical book publishers, instrument salesmen, and detail men, as the doctor will want to see them if he is not too busy, for he likes to hear about what is new on the market. They will appreciate your co-operation. In contrast to this we have the necktie and hosiery salesmen, real estate men, and peddlers of all sorts. These should never be allowed to see the doctor; his time is much too valuable to waste on them, nor must you spend any time with them.'

In warning against unethical talking, it is pointed out

that every office nurse should realize that she is not a diagnostician, and that beyond being courteous she has no business discussing, even with a patient, his problem which the medical expert alone must solve. "In casual conversation, if you do talk about the doctor, give him a boost, say something about his skill and ability, or tell them of some of the charity work he does (never mention names) so that your listeners will know what a competent man he is."

And perhaps most important of all, the nurse should be both polite and diplomatic when talking to patients or prospective patients on the telephone."

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AUXILIARY

PRESIDENT'S MESSAGE

Since our country is at war, the first question that confronts each and every one of us is: "What can I, personally do to assist in civilian defense?" Your President and your press and publicity chairman visited Mr. Jeff Robinson in his office in Topeka. He advised that each of us register individually and not as an Auxiliary. Let us take our places promptly wherever we can work most efficiently. Our National President urges us to expend to the fullest extent possible our present program on health education. We realize that health and war time efficiency are inseparable. We also urge you to enroll as volunteers with the local defense councils and may we strive to be informed leaders in the field of nutrition and health. Co-operate with the Red Cross and with other national organizations whose program in health defense is approved by the American Medical Association.

We must be watchful that we are not swayed by prejudice and propaganda. We must think things through and then have the courage to stand by our convictions. Above everything else, we as homemakers, must keep up the morale of our homes. We must live simply and as normally as possible. This world crisis is a challenge to us all and so let us determine to keep up our high standards to the end of the struggle.

Sincerely,
Mrs. W. Y. Herrick.

Since "Every Doctor's Wife for Defense" is our desire this year, an increased Auxiliary membership is imperative. We, as wives, need authentic information on health problems, especially foods, and auxiliaries are making a special study of these as we have access to accurate knowledge which some groups do not.

We have about ten weeks left this year to contact the unorganized counties, prospective members and members-at-large. Will you assist your councilor as she has a large district to cover and needs help?

We are stressing personal contacts this year so please explain personally our objectives and accomplishments. Altho we have about 28,000 members in the United States we need the help of every doctor's wife in Kansas.

This year an article concerning auxiliary work is being included in the bulletin sent to the president and secretary of each county medical society. We feel the only reason every doctor's wife is not a member is because she has not yet been advised of the importance of the work.

Dr. Lahey, President of the American Medical Association, says the Auxiliary can promote unity and that the present situation is serious enough to make all of us work with a unified purpose.—Irma Blasdel, State Organization Chairman.

PLEASE NOTE—Any suggested revisions of the Constitution or By-laws must be in the hands of the State Parliamentarian, Mrs. J. B. Carter, not later than March 1. Address her in care of the Mother Bickerdyke Home, Ellsworth.

Mrs. H. L. Regier of Kansas City has been appointed as Secretary to fill the unexpired term left vacant by Mrs. C. H. Warfield who has moved to Illinois. Dr. Warfield is in charge of the x-ray department in the Great Lakes Naval

hospital of 1000 beds. Their address is 415 N. Lewis, Waukegan, Illinois.

As State Chairman of Archives and History it is my duty to obtain histories from all auxiliaries and to record the activities of the Society for the year 1941-42 with space so each auxiliary will be individually represented.

The History may contain:

1. An interesting account of the circumstances surrounding early organization.
2. By whom organized.
3. Others cooperating.
4. Time and place of meeting.
5. Officers elected.
6. Members or charter members.
7. Activities.
8. Health education.
9. Hygeia.
10. Special projects and significant dates.
11. A record of each subsequent year, officers, members who have held district, state, or national office.
12. A brief summary of each annual meeting, time, place, special speakers, outstanding reports, budgets, etc.

I would like for each auxiliary to be sure and get its history up to date, if you have not already done so, and keep it up to date. Also I would like each Historian to list all auxiliary activities so we may have a record of them.

Please label from what auxiliary your clippings are being sent from, to avoid getting them mixed.

I am so proud of the records sent in last year, and want to thank all of you for the help and cooperation given to me. Let us all work together again this year. Thanking you.
Mrs. H. H. Woods.

AUXILIARY MEETINGS

The Woman's Auxiliary to the Saline County Medical Society held a meeting in the home of Mrs. Charles Jenney in Salina on January 15. Dinner was served by Mrs. Jenney, Mrs. R. L. Druet, Mrs. L. W. Hatton and Mrs. L. S. Nelson. The Saline Auxiliary members are knitting and sewing for the American Red Cross and assisting with the military hospitality committee that oversees the entertainment of the troops from Fort Riley on week-ends.

The Woman's Auxiliary to the Sedgwick County Medical Society met in Wichita on January 12 for a one o'clock luncheon. Mrs. Wilfred Cox of Wichita was the hostess. Mrs. J. E. Wolfe gave a book review. The board voted to cancel the February guest day tea and substitute a war relief donation of \$25.00 to the Red Cross, as a part of the auxiliary program. The auxiliary held a luncheon on February 9 at which Mr. Henry J. Allen of Emporia was the guest speaker. Plans for organizing a Red Cross Unit within the auxiliary were discussed. Mrs. W. J. Kiser, Hygeia Chairman, announced that over one hundred subscriptions had been placed.

A Board meeting was held on January 6 at the home of Mrs. B. P. Meeker and a business session followed the dinner.

The Woman's Auxiliary to the Shawnee County Medical Society held a luncheon at the home of Mrs. T. A. O'Connor in Topeka on February 9. Dr. F. C. Beelman of the Kansas State Board of Health spoke on "Tuberculosis Control" and showed slides on the subject, also a film on "Good-bye Mr. Germ." Mrs. W. Y. Herrick of Wakeeney, State President of the Auxiliary was a guest and spoke on the "Objectives of the Auxiliary."

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THE SIGNIFICANCE OF VOMITING AND DIARRHEA AMONG INFANTS AND CHILDREN*

Roger L. J. Kennedy, M.D.**

Rochester, Minnesota

Of all the symptoms related to disturbances of the gastro-intestinal tract among infants and children, vomiting and diarrhea are by far the most common. The ability to evaluate properly the significance of these symptoms implies a knowledge of the possibilities of underlying disease or disturbance that may account for them. Their significance may vary greatly according to the different ages of the infants and children.

VOMITING

Among newborn infants.—If a newborn infant begins to vomit shortly after birth or following the first feeding, certain conditions must be suspected. Foremost among these is congenital atresia of the esophagus or of the duodenum. In case of the former condition, the vomiting is likely to occur during or immediately after the feeding. If the latter condition is present, the food, whether it be a solution of dextrose or milk, may be retained as long as an hour or two before being vomited. In case the obstruction is in the esophagus, attempts to pass a stomach tube will be prevented by the stricture or stenosis. If the obstruction is due to a tracheo-esophageal fistula, it is likely that a roentgenogram of the abdomen will disclose that the stomach is filled with air. Confirmation of a presumptive diagnosis of congenital atresia or narrowing of the esophagus can be obtained by the administration of a small amount of thin barium or of opaque oil, followed by roentgenologic study. If the vomitus contains bile, if the upper part of the abdomen is distended and if the opaque medium fails to pass into the jejunum, the atresia may be definitely located in the duodenum.

Occasionally vomiting may begin at birth and continue intermittently. Some of the feedings may be retained, but others are expelled in part or whole, either a short time or some minutes or hours after feeding. The infant may appear normal in all other respects, but percussion of the thorax may disclose some impairment of resonance on one side or the other. The probability that a diaphragmatic hernia is present will then be greatly strengthened, if gurgling sounds and sounds suggestive of intestinal peristalsis are elicited by auscultation. In order to confirm such a diagnosis, roentgenologic study after the ingestion of barium should be made. Usually, a portion of the stomach or a segment of the small intestine will be visualized in one or the other thoracic cavity. Examination after the administration of a barium enema is also indicated, as sometimes the colon alone or together with other abdominal viscera is intrathoracic.

Persistent vomiting of most of the food and water ingested by a newborn infant may take place in cases in which there is a history that suggests the possibility of cerebral trauma at birth. Such infants are usually inactive, stuporous or hyperirritable and there is a history of twitching of muscles, convulsions or cyanosis that lasts several hours or days after birth.

Among infants a few weeks of age.—In the case of infants who have attained a few weeks to about two months of age, the presence of vomiting suggests other conditions. It is important that the frequency, time and nature of the vomiting be known. If it occurs after every feeding or after nearly every feeding, if it appears either soon after feeding or just before the time for the next feeding, and if it is forceful or projectile in type, it becomes likely that there is some obstruction to the passage of food from the stomach to the intestine. Since there is little or no food passing into the bowel, the stools may be infrequent and scanty and the weight of the infant either remains stationary or decreases. Such a history as the foregoing should lead the physician at once to observe carefully the abdominal wall. The presence of peristaltic waves on the surface of the abdomen, which travel from the left upper quadrant toward the right midabdomen, and which at times cause a dumb-bell shaped pattern to stand out in strong re-

*Presented at the 82nd Annual Session of The Kansas Medical Society, Topeka, May 14, 1941.

**Section on Pediatrics, Mayo, Clinic, Rochester, Minnesota.

lief against the rest of the abdominal wall, establishes a diagnosis of obstruction of the pyloric end of the stomach with a high degree of certainty. The finding of a gas-filled stomach and the failure of barium to pass the pylorus when observed roentgenologically will confirm the clinical impression.

Further investigation may determine more accurately the exact site of the obstruction. If a firm olive-shaped mass with the consistency of cartilage is palpable in the right upper part of the abdomen just below the edge of the liver, it is likely that hypertrophic stenosis of the pylorus is accountable for the vomiting. On the other hand, if such a mass is not palpable, the diagnosis is not appreciably weakened as such a mass frequently is not palpable.

Additional diagnostic help may be derived by noting the character of the vomitus. If it consists only of food, or only of food and mucus, the obstruction likely is at the pylorus, and as hypertrophic pyloric stenosis is by far the most common cause of pyloric obstruction among infants of the age under consideration, the probabilities are great that hypertrophic pyloric stenosis is present. If, however, the vomitus contains bile in addition to food and mucus, the obstruction is beyond the opening of the bile ducts into the duodenum. In such instances so-called congenital bands must be considered. These are bands of fibrous tissue that extend from the mesentery of the small intestine to the region of the hilus of the liver in such a manner as to decrease or obliterate the lumen of the duodenum.

Among older infants.—Sudden vomiting accompanied by evidence of pain may occur among otherwise healthy infants from a few months to a year of age. If the pain is intermittent in type, as evidenced by alternate periods of quiet and of crying or screaming, it is safe to assume that it is due to true colic, that is, to contraction and relaxation of smooth muscle. Examination of the abdomen while the infant is crying will be of no avail, but if the abdomen is carefully palpated while the infant is quiet, a sausage-shaped mass may be found at the site of the ascending colon or the ascending and transverse colon. This should lead at once to the suspicion of intussusception of the ileocolic or of the colocolic variety. Rarely a mass may be palpated elsewhere in the abdomen if the intussusception is of the ileoileal type. If, in addition to evidence of colicky pain and the presence of an abdominal mass, there are also bloody passages from the rectum and if rectal examination discloses a mass in the lower part of the bowel, the diagnosis of intussusception becomes definite.

Fever, in addition to vomiting, has not been mentioned. If fever is present, infection must be con-

sidered. This necessitates a thorough and painstaking examination. An acute cold may be ushered in by vomiting as well as fever, and it can usually be recognized by the story of sneezing, nasal discharge, irritability and anorexia. Examination of the pharynx and of the thorax may elicit findings characteristic of acute pharyngitis, tonsillitis, acute bronchitis, or even pneumonia. In such instances the reason for the vomiting becomes obvious. Vomiting and fever may, however, be present for a day or two without any apparent cause. The possibility that they may be due to the onset of one of the contagious diseases, particularly scarlet fever, must be borne in mind. It is sometimes a matter of surprise to find that these symptoms may be explained by the finding of a red pharynx and pillars, a coated tongue and a palate with the characteristic punctate hemorrhagic lesions of scarlet fever. One must be on guard not to mistake vomiting, fever and abdominal pain for symptoms of acute appendicitis, when the explanation for these symptoms can be found by demonstration of Koplik's spots which are pathognomonic of measles.

Among infants and children of all ages.—Vomiting and fever may be the only symptoms indicative of illness of infants or children of any age. Complete and thorough physical examination may not disclose any abnormality, yet the physician recognizes that infection is present somewhere in the body. If he will examine with a microscope a drop of urine obtained by catheterization, the diagnosis may at once be clarified. Not only leukocytes, singly and in clumps, but myriads of bacteria may be visualized. These findings indicate beyond doubt that there is an infection of the urinary tract. Sources of error in this connection are the finding of leukocytes or bacteria in a specimen voided by a female patient or bacteria in a specimen which has stood for an hour or more in a nonsterile container. If somewhat more exact information regarding the type of infecting organism is desired, it may be obtained by the simple expedient of allowing a drop of freshly catheterized urine to dry on a glass slide and then staining it with Gram's stain. This will differentiate bacilli and cocci and will thus indicate somewhat more definitely the type of medication indicated.

Whenever vomiting and fever are accompanied by abdominal pain, careful examination of the abdomen is obviously indicated. If tenderness can be elicited by firm pressure over or near McBurney's point, appendicitis (or mesenteric adenitis from which it frequently cannot be distinguished) is almost surely present. If a point of maximal tenderness cannot be elicited, or if examination of the abdomen does not disclose any abnormality, especially in the case of very young patients, it is necessary to rule out otitis media,

acute pharyngitis, acute tonsillitis and pneumonia. In early pneumonia, before the signs in the thorax have become clear, there may be evidence of abdominal pain and examination of the abdomen may elicit tenderness. The tenderness, however, is likely to be superficial, that is, it may be elicited by relatively light pressure, whereas increasing pressure may be exerted until the palpating fingers come into contact with the resistance of the posterior abdominal wall without any indication on the part of the patient that the discomfort is greater or even as great. At the same time no increase of muscle spasm will be encountered unless there is real peritoneal irritation or inflammation of the walls of the appendix. If doubt exists as to the presence of acute appendicitis or of pneumonia, time should be taken to secure a roentgenogram of the thorax. Careful examination of the tonsils and pharynx and roentgenographic examination of the thorax have frequently saved young patients from being subjected to appendectomy.

A particularly hazardous time for a young patient exists if he begins to vomit and has fever and abdominal pain when other members of the family and community are having similar trouble. Just what accounts for the so-called stomach flu or stomach and intestinal flu is not yet clear. The possibilities that the young patient is suffering from this disturbance are great, but the responsibility of the physician cannot be discharged by jumping to this conclusion. Examination may reveal that the patient has very definite local tenderness in the region of McBurney's point as well as tenderness in the right side of the pelvis as revealed by digital examination of the rectum. Practically every season during which "stomach" or "stomach and intestinal flu" prevails, one or more young patients with acute appendicitis are allowed to go without surgical treatment until perforation and peritonitis with their resultant sequelae develop because the parents and occasionally the physician have concluded that the trouble is "only another instance of flu." The point to be emphasized in this connection is that in every case in which the child complains of abdominal pain a careful examination, including the abdomen, should be made to rule out appendicitis regardless of the prevalence in the family or community of other less serious illnesses.

In cases in which attacks of vomiting have occurred for months or years, it may be necessary to differentiate organic and functional disease. Peptic ulcer, although of comparative rarity during childhood, must be thought of as a possible cause. It seldom produces the same symptoms among children as it does among adults, that is, epigastric pain which is relieved by eating and by taking bicarbonate of soda, pain which is increased by the ingestion of food

of certain kinds, pain which comes on in an hour or two after eating, and vomiting of retained food in case there is a duodenal or pyloric obstruction. Improper eating habits also must be eliminated as a possible cause. A history of forced feeding, eating at irregular intervals, improper selection of food and vomiting during or immediately after eating suggest the presence of a functional disturbance. If, however, the history reveals that the attacks start without preceding illness, continue for a day to several days and consist of the vomiting of everything that is ingested, even water, the condition is probably, but not always, cyclic, periodic or acidotic vomiting. During an attack the eyes are sunken and the child is pale, hypotonic and sometimes even stuporous.

Roentgenographic examination of the stomach and duodenum may eliminate other possible causes. Even this procedure may not help to recognize certain conditions which intermittently cause partial or complete obstruction of the upper part of the gastrointestinal tract. In one instance the true nature of the vomiting was not recognized until operation, which disclosed torsion of the duodenum which pursued an anomalous course through the mesentery of the transverse colon.

Persistent vomiting, even without headache or other obvious signs of physical impairment, should be an indication for examination of the ocular fundi. A roentgenogram of the skull and a complete neurologic examination should be made in order to rule out the presence of increased intracranial pressure which in the case of a young patient is due most frequently to an intracranial tumor. In one case, ophthalmoscopic and neurologic examinations resulted in a diagnosis of tumor of the brain within five days after the onset of vomiting.

DIARRHEA

The necessity for complete physical examination and sometimes for laboratory study is no less important in cases of diarrhea than it is in cases of vomiting. One of the most serious and most feared conditions that may affect infants in a ward for newborn babies is the so-called epidemic diarrhea of the newborn. Although the cause of this malady is not known, those in charge of nurseries for newborn infants are only too well aware of the possibilities of an outbreak of this disease in the nursery. They must be on the alert for the passage of loose frequent stools by anyone of the tiny patients under their care. At the first indication of such symptoms the strictest isolation must be instituted and intensive treatment begun.

If the infant is brought to the physician because of frequent loose stools and if the infant's general condition is good, attention must first be accorded

to the feeding history. Overfeeding, too frequent feeding and feeding at irregular intervals may be evident from the history. In the case of artificially fed infants the nature of the formula which they have received may be at fault.

If the diarrhea has just recently begun, examination may reveal otitis media, an infection of the upper part of the respiratory tract or evidence of some other acute parenteral infection. The intestinal tract is especially sensitive to such infections and they must be eliminated in every case.

If the infant is obviously very ill, if parenteral infection has been eliminated by examination, and if there are many thin loose watery stools with marked dehydration, ashen gray pallor and slow deep breathing, the serious disturbance formerly called "cholera infantum" and now more generally designated as "intestinal intoxication" or "toxicosis" is probably present.

Intestinal intoxication seldom affects infants past two years of age; therefore, if the child is older than two years and particularly if there is much blood, pus and mucous casts of the intestinal tract in the stools, bacillary dysentery may be diagnosed with reasonable certainty. Cultures of freshly evacuated stools may reveal the presence of Shiga's bacillus, and if this is found the diagnosis can be said to be established.

Although comparatively rare at the present time, typhoid fever must be kept in mind as a possible explanation of a diarrhea which has lasted for several days or longer. The fact that this disease has become rare should not be reason for failure to examine for sustained fever, slow pulse, rose spots, splenomegaly, positive agglutination test and the presence of typhoid bacilli in the blood and stools.

In cases in which infants or children have diarrhea which has lasted weeks, months or even years, several conditions must be considered. If the history reveals that the diarrhea began in early life, consisted of six to ten or twelve large, light colored, frothy stools having a very offensive odor, and if there has been retarded physical growth, celiac disease or chronic intestinal indigestion is the most likely cause.

In recent reports of cases in which all of the foregoing symptoms occurred, an explanation of the disease has been found in the presence of a cystic and fibrous pancreas. In some of the cases there also has been evidence of chronic pulmonary disease. Children affected with either disease are small, stunted, have a large protuberant abdomen and the stools contain large amounts of fats. Tuberculous peritonitis may occasionally be suspected in such cases but the characteristic history, physical appear-

ance of the patient and the absence of a positive tuberculin test should be sufficient evidence upon which to make a differential diagnosis.

Examination of the stools as well as proctoscopic examination and roentgenologic examination of the colon must be carried out in case the history discloses that the diarrhea is of long standing and that the stools contain blood and mucus. Chronic ulcerative colitis is the condition that is most likely to be present, especially if the examination of the stools fails to disclose the presence of *Amoeba histolytica* and if proctoscopic examination reveals the characteristic appearance of the mucosa of the rectum and sigmoid. The characteristic narrowing of the lumen and the absence of the normal markings or haustra of the large intestine may be evident in the roentgenogram. These findings give to that part of the bowel the characteristic appearance that has been described as that of a lead pipe.

Less frequently than in cases of chronic ulcerative colitis, diarrhea may consist of not more than two or three stools a day and there may be blood but relatively little mucus. Digital examination may reveal numerous small pea to acorn sized masses projecting from the mucosa of the rectum. In such cases proctoscopic examination will show these to be polyps, and roentgenographic examination of the colon by means of contrast medium, will disclose that these are part of a condition called polypoidosis of the colon.

"Today the crown for pre-eminence in healing belongs to the United States. This is all the more astonishing when one considers that thirty years ago the standards of admission to our medical schools were lower than in any civilized country, that our hospitals, on the whole, were far below Viennese standards of efficiency, and that our medical research was laughed at in every laboratory of Central Europe.

Many men still in practice have lived through this dramatic transformation. They have seen Viennese leadership decline for more than twenty years and then go into complete eclipse under the oppression of a hater of scientific truth. They have seen American hospitals reach heights of efficiency undreamed of in the old *Krankenhaus*. They have seen the standards of American medical schools change from the lowest in the civilized world to the highest.

Today they see American medical research occupying thousands of devoted workers and saving lives all over the world. Of 410 medical discoveries made from 1926 to 1938 and listed by the National Geographic society, seventeen can be credited to Germany and Austria, thirty-five to the British empire, twenty-two to other countries, and 336 to the United States!

It is our responsibility to carry on research for lands where medical science has been set back by generations, to keep alive the spirit of scientific inquiry stifled in totalitarian countries. And today we are equipped to meet this enormous responsibility. The U. S. A. has become the medical center for all mankind!"—Elsie McCormick in the *American Mercury*.

BENIGN TUMORS OF THE MESENTERY*

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It has been said that there may be little justification for reporting isolated cases of an established disease entity from which no significant conclusion can be drawn. However, progress is made through the accumulation of scientific data and there is a stimulus to more accurate diagnosis and effective treatment from a review of rare surgical conditions. We will briefly review the subject of benign solid and cystic tumors of the mesentery and report two personal cases.

Tumors which have their origin between the leaves of the mesentery are quite rare. The first fibroma was reported by Bricheteau in 1824. In 1880 the first successful operation for removal of a mesenteric tumor was performed by Tillaux. Harris and Herzog¹ in 1897 found fifty-six cases of solid tumors of the mesentery which had been reported in the literature up to that time. They were classified as follows: carcinoma, sixteen; lipoma, fifteen; sarcoma, seven; and fibroma, six cases, being the rarest.

In 1936 Hart² reported that a thorough review of the literature up to that time revealed 186 reported cases of solid tumors of the mesentery while cystic tumors were more common, the ratio being two to one. In the fifteen years after 1920, he found reported in the literature, twelve cases of lipoma and twenty-six of fibroma, or thirty-eight additional cases of benign tumors of the mesentery. Only six cases of fibroma have been reported in the past five years.

Another angle on the frequency of occurrence of mesenteric tumors is secured from the statement of Judd and Crisp³ in an article from the Mayo Clinic in 1932. They reported that twenty-five cases of tumors originating between the leaves of the mesentery occurred among 820,000 admissions. In these twenty-five, there were eight benign cysts, five lipomas, two fibromas, one fibromyoma, two degenerating fibromas (in the same patient), and eight sarcomas. We can safely say that the majority of solid tumors of the mesentery are benign and that when malignant, the grade of malignancy is low and that metastasis does not occur early. Benign mesenteric tumors rarely undergo malignant degeneration. The fibromas are found most frequently in the small bowel mesentery and especially near the lower ileum.

Benign primary mesenteric cysts are more com-

mon than solid tumors and are divided, according to Ewing in his book on Neoplastic Diseases, into four varieties: (1) lymphatic, or chylous cysts, which contain clear chyle or inspissated fat; (2) enteric, which do not concern us where they have any connection with the intestinal tract since the term mesenteric tumor should be restricted to those tumors which have no connection with any organ except by areolar tissue; (3) urogenital, which contain a brownish serous fluid; and (4) dermoid or teratoid. There is still disagreement on classification and their origin has not been proved. Except in the case of the dermoid no conclusive information concerning the origin of the tumor is gained from histological examination. The commonest findings are either a cyst wall, composed of fibrous tissue, or a flat endothelial layer surrounded by fibrous tissue. Half of the mesenteric cysts occur in the mesentery of the small bowel. The majority are unilocular and the cellular lining may have been destroyed. The contents may indicate some accident which has overtaken the cysts and only rarely have any bearing on the origin of the cyst.

Penberthy and Brownson⁵ in 1938 stated that "dermoid cysts of the mesentery are the rarest of all mesenteric tumors. The total number of mesenteric tumors reported in the literature since the sixteenth century is approximately 500 cases. Of these 500 cases less than twenty have been proven dermoid cysts of the mesentery. In the other cases reported the content of the tumors was a fat-like substance in which no hair or ectodermal derivatives were found." These authors believe that only fourteen cases have been proven dermoid cysts of the mesentery to which they add one case.

From the embryological point of view a mesenteric tumor might arise from displaced remnants of the wolffian body or its duct or the muellerian duct but there is rarely microscopic proof that it has any such origin. It is interesting to note the variety of tissue found in these tumors and this is not surprising when we consider that the mesentery is simply a sheet of mesenchyme covered with mesothelium. Within this structure are blood and lymph vessels, lymph nodes and nerve fibers and any of these tissues may become the site of a tumor.

It is probable that both solid and cystic mesenteric tumors should be considered as retroperitoneal tumors for they have a common origin both embryologically and pathologically. It is also probable that some originate retroperitoneally and grow forward between the leaves of the mesentery or mesocolon. However, clinically we must classify them by location rather than by origin.

Mesenteric tumors, both solid and cystic, are

* Presented at a meeting of the Western Surgical Association, St. Paul, Minnesota, December 6, 1941.

found in all ages, most commonly in the third decade, and more often in women. They are most frequently situated in the lower abdomen and more frequently to the right of the mid-line.

The symptomatology is naturally varied when we consider the differences in size of the tumor, in its location as to the portion of intestine whose mesentery is involved, and in the proximity of the tumor to the bowel. Certainly the size of the tumor and the amount of pressure made account for the symptoms prior to the development of complications. Many cases are silent except for the presence of a movable tumor. This mobility, especially in the solid tumor cases, is greater laterally than vertically and is less in larger tumors. The mesenteric cysts are more perfectly rounded and their consistency may suggest the diagnosis. A common characteristic is that the tumor is crossed by intestine and the low abdominal cases usually have a zone of tympany between the tumor and the pubis.

Patients may have dull dragging pain, or recurring attacks of severe abdominal pain. Constipation or alternating constipation and diarrhea may be present. There may be increased peristaltic activity above the site of the tumor. Patients with mesenteric tumors do not lose weight as a rule and the symptoms are rather vague.

With the onset of acute intestinal obstruction the primary condition is completely overshadowed. Strangulation of the tumor or intra-abdominal hemorrhage may cloud the picture. Warfield⁶ has analyzed in detail the complications of mesenteric cysts.

Diagnosis is usually not made pre-operatively due to the fact that mesenteric tumors are rarely encountered. In general a movable tumor, shown by x-ray to be outside the intestinal and renal tracts, and crossed by intestine with a tympanitic zone below it, should arouse our suspicions. Pneumoperitoneum plus x-ray may help and peritoneoscopy can be employed to advantage. Certainly the diagnosis will be made more frequently if this condition is thought of and considered.

The treatment is entirely surgical. Enucleation when feasible is the simplest procedure, however, many cases will need intestinal resection as well. Marsupialization of mesenteric cysts is not modern surgical treatment.

The operative mortality which was high in the earlier reported cases, is now in the neighborhood of twenty per cent. It is low in cases where enucleation can be done and higher when resection is necessary. Modern pre-operative treatment of obstructed cases, with the addition of sulfonamide implantation

in resected cases should reduce mortality in the future.

The first case report is one of fibroma of the mesentery.

CASE REPORTS

Mrs. S. F., a white housewife, aged sixty-eight, was admitted to Stormont Hospital March 18, 1941. There was no history of other tumors in the family and the patient's mother lived to the age of ninety-three.

She had had two children, both of whom were in excellent health, and her menopause eighteen years before had been uneventful. Since that time there had been no further bleeding, discharge, or other symptoms. She had had no previous operations.



Fig. 1. Fibroma of mesentery.

One year before admission she noticed that her dresses were becoming tight around the waist and a little later noticed a lump in the abdomen. She had no pain or symptoms referable to this enlargement so she did nothing about it, feeling it was of no importance. However, six months before admission the tumor mass began to grow quite rapidly, and since dressing had become a problem and she had considerable discomfort from the weight and pressure in the abdomen, she finally consulted her physician.

During the month before admission she had experienced increasing difficulty in getting her bowels to move and had been forced to take laxatives. In the three days preceding admission, the sensation of weight and pressure had increased to the point where she complained of pain.

With the exception of the abdomen, the physical examination was of no particular interest. There was a large, mid-line, lower abdominal tumor the size of a six-months' pregnancy which extended to a point above the umbilicus. The tumor, in general, was rounded in shape, irregular in contour, and very firm. It was slightly movable, especially laterally. The abdomen was soft throughout, with no rigidity, and no evidence of free fluid. There was no zone of tympany below the tumor. The tumor mass was entirely above the pelvis and could not be felt on vaginal or rectal examination. The uterus was small and atrophic and no adnexal masses could be felt. There was no rectal shelf.

Barium was not given so as not to aggravate the obstruc-

tive symptoms. The Wasserman test was negative. Examinations of the urine and blood were essentially negative.

Diagnosis before operation was a solid tumor, probably of ovarian origin.

Operation disclosed a tumor mass about eight inches in diameter, of rather grayish color, hard consistency, nodular, covered by both leaves of the mesentery and crossed by one loop of small intestine which stretched rather tightly around more than three-fourths of the circumference of the tumor. Posteriorly and to the right of the mid-line the leaves of the mesentery were widely separated so that there was an area of tumor not covered by peritoneum. Upon exploration of the abdomen no metastases were found in the liver or elsewhere in the peritoneal cavity. It was then decided to remove the tumor, combined with a resection of the attached intestine.

The limb of the intestine on the right side was divided between clamps and the division carried down through the mesentery. Retroperitoneal attachments of the tumor were then divided, clamping numerous vessels. The limb of the intestine attached to the left side of the tumor was then divided with its mesenteric attachments and the tumor removed. There was a long section of avascular intestine above the portion which had been previously resected on the right and this made necessary the removal of two feet more of small intestine. The open ends of the intestine were closed and a side-to-side anastomosis done. Closure was made of the open peritoneal surfaces on the posterior abdominal wall. The abdominal wall was closed without drainage. A transfusion of 500 cc. of citrated blood was given.

The patient had a rather stormy post-operative course complicated by an infected abdominal incision but made a complete recovery and is enjoying perfect health.

Pathological report by Dr. H. R. Wahl says: "One of the sections shows rather dense masses of hyaline fibrous tissue arranged in irregular interlacing sheets and bundles often containing hyperplastic appearing nuclei, some of which seem to be rather large and hyperchromatic. A tendency to hyaline degeneration of some of the connective tissue cells and fibers is frequently seen. In other fields the tissue is much more cellular and the intercellular substance is not as prominent. In these more cellular areas, the picture somewhat simulates the cellular myoma. On the other hand, special stains made upon this tissue fail to reveal any definite muscle element. There is not much variation in size, shape and staining. The tissue evidently represents a fibroma which is more cellular in some places than others associated with a variable amount of hyaline degeneration, even hyaline necrosis with beginning deposits of calcium salts. It is probably not malignant, but a rather large and extensive retroperitoneal fibroma."

The other case report is one of a cyst of the mesentery which I will report briefly since it was found in the course of operation for another lesion.

Mrs. C. R., a white housewife, aged forty-seven, entered Stormont Hospital March 6, 1940, with all the clinical and roentgenological evidence of a carcinoma of the left colon which had been causing definite symptoms for the past year. In connection with her past history she stated that for years she had noticed a movable tumor in the left side of the abdomen at the level of the umbilicus.

Physical examination showed a hard, irregular mass as large as a grapefruit in the left upper abdomen. This was distinctly palpable both anteriorly and posteriorly. We were unable to distinguish any movable tumor from the

general mass. Pyelogram made before admission to the hospital showed no renal involvement.

Operation disclosed a rounded cystic tumor two and one-half inches in diameter in the mesentery of the jejunum adherent to a large carcinoma which involved the upper part of the descending colon. The whole mass was mobilized so that it could be delivered. This necessitated extensive retroperitoneal dissection and division of a section of the mesentery of the small intestine next to the cystic

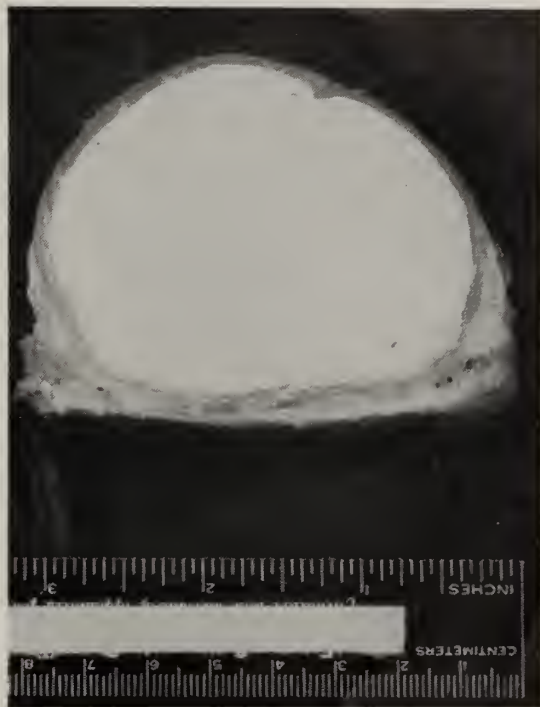


Fig. 2. Mesenteric cyst cross section.

tumor. The portion of small intestine surrounding the cystic tumor was resected and an end-to-end anastomosis made with two layers of sutures. Obstructive resection of the colon using a Rankin clamp completed the operation.

The patient made a good operative recovery but died six months later from metastatic carcinoma.

Dr. Wahl's pathological report states: "This rounded tumor is made up of an opaque, light colored, cystic wall which ranges from four to five mm. in diameter and is quite fibrous, being fatty on the outside and the inside smooth. The base consists of mainly fatty and fibrous tissue in which there appear several lymph nodes which have a hyperplastic appearance. The contents of this cyst is made up of a homogeneous putty like yellowish gray caseous material. No hair or teeth are present.

The first group of sections taken through the wall shows nothing but dense hyaline fibrous tissue without any epithelial lining and foci of monocytes in the outer portion of this fibrous capsule or wall. Additional sections cut through the same tissue show a perivascular inflammatory reaction in the wall, many leukocytes of a mononuclear type and plasma cells are seen around some of the blood vessels. These inflammatory foci are often quite numerous and rather large. There is no epithelial lining that could be recognized.

A section through what is apparently a lymph gland

shows nothing but chronic inflammatory reaction in a lymph gland. It has the appearance of a probable dermoid cyst.

Diagnosis: Retroperitoneal dermoid cyst (?) showing some secondary inflammatory reaction also chronic hyperplastic lymphadenitis."

This cyst would probably not be classed by Penberthy and Brownson⁵ as of dermoid origin since no definite epidermal structures can be identified. The diagnosis of dermoid is justified if we assume that intracystic pressure may account for the disappearance of the cellular structure which was responsible for the cheesy secretion. Although the findings are similar to a case reported by Judd and Fulcher⁴ in an article entitled *Dermoid Cysts of the Abdomen*, it cannot be regarded as a proven dermoid cyst.

SUMMARY

A review of the history of benign mesenteric tumors is given. Symptoms may be those of a silent tumor, of vague abdominal symptoms or of an acute abdomen. Two case reports—a fibroma and a cyst which were successfully resected are given.

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"Physicians are dying needlessly every year of advanced disease . . . many have never had a physical examination since they were examined for life insurance . . . it is a real tragedy to find hopeless advanced cancer in a physician." These calamitous lines appear in a *Bulletin for the American Society for the Control of Cancer*.

In contrast, one reads in the September issue of the *Metropolitan Life Insurance Bulletin*: "New Army in Excellent Health," "Average Length of Life Increased by One-Third Since 1900," and "Health of American Wage-Earners Remains at High Level"—but at what level is the health of the American doctor?

Perhaps patriotism will at last accomplish what family admonitions and mere possession of knowledge have failed to do, for a doctor's health is no longer a personal matter but one of vital public concern. To maintain the health of the nation—"our first line of defense"—is not an easy task under any conditions but it is now made doubly hard by the acute shortage of physicians due to so many having been called into military service. We can no longer break the rules. It is time to take our own medicine.

"In gratitude for his work in removing delayed action bombs which fell in the east end of London, Capt. Robert Davis, who is in command of the bomb disposal squad, has been presented with a stethoscope by the resident staff of one of the hospitals. He has frequently borrowed a stethoscope from the hospital in order to listen to the ticking of delayed action bombs before removing them."—*British Correspondent in Journal of the A.M.A.*, March, 1941.

INCIDENCE OF SYPHILIS IN PRIVATE PRACTICE

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The incidence of syphilis is a subject that has received widespread attention from a number of different viewpoints. A confusingly large variety of figures and conclusions are to be found. Such a widespread divergence in the results of research is due to the several factors affecting each particular study. However, the chief factor responsible for considerable variation in results is the character of the group upon which the study is made, and this must be held in mind in any study upon the incidence of syphilis.

The statistical results presented in this paper are considered to be of interest because they represent the findings of a large group of patients whose social and economic standing would be of the type most frequently encountered in private practice. These patients were those seen and examined either in the office or in the hospital in the course of a practice limited to internal medicine, and represent a cross-section of the people of Kansas, nearly all belonging to the white race.

Complete histories, physical and laboratory examinations, including routine Wassermanns, were done on 10,000 consecutive office and hospital patients, extending in time from 1921 to 1939, inclusive. A diagnosis of syphilis was made only on conclusive clinical findings or conclusive serological findings. All positive Wassermann tests, unless there was also conclusive clinical proof of syphilis, were checked on a second specimen of blood at a second laboratory in order to rule out any chance of error.

The following results from the standpoint of the diagnosis of syphilis were obtained:

Blood Wassermann 4+	174 cases
Blood Wassermann 3+ (definite syphilis)	13 cases
Blood Wassermann 2+ (definite syphilis)	8 cases
Blood Wasserman Negative (definite syphilis)	13 cases

Total 208 cases

Thus, it is seen that 2.08 per cent of all the cases proved to be syphilitic. The actual incidence of syphilis would be slightly higher, as an occasional case with a negative blood Wassermann and a positive spinal fluid Wasserman would be overlooked because of symptoms insufficient to justify a spinal puncture, and it is also well known that occasional cases of syphilis proven at autopsy have a negative Wassermann. However, these two factors would add

only a few cases and would only slightly increase the total incidence of syphilis.

Two small groups of patients have been omitted from the above statistics:

- (2) Several cases with a definite history of a previous syphilis, followed by adequate treatment and negative clinical and serological findings when seen. Such cases were considered cured and not included in the syphilitic cases.

- (2) A small group of patients having a weekly positive 1+ or 2+ Wassermann reaction without any clinical evidence of syphilis.

These were not considered to be syphilitic.

An analysis of the thirteen cases of definite syphilis with a negative blood Wassermann is of interest, and is as follows:

Chancre with positive dark field.....	2 cases
Positive spinal fluid Wassermann.....	4 cases
Definite tabes and no spinal fluid test made	6 cases
Definite syphilitic aortitis.....	1 case
Total	13 cases

In this series of 208 cases, the sex distribution was as follows:

Males	121 cases, or 58%
Females	87 cases, or 42%

The inability to depend on a history of a primary infection in making a diagnosis of syphilis is demonstrated in this group of cases as evidenced by this fact: that of the one hundred twenty-one male cases only forty-five, or thirty-eight per cent; and of the eighty-seven female cases only six, or thirteen per cent, admitted knowledge of a primary infection.

Of special significance are those cases of syphilis which were detected solely by the routine Wassermann test. Of these there were one hundred three, or forty-nine per cent of the two hundred eight cases. These patients gave no indications, from clinical history or physical examination, of the presence of syphilis, and the diagnosis of syphilis would have been overlooked had not routine Wassermann examinations been made. Most of these cases represent a syphilis which is latent at the time of examination.

A summary of the clinical diagnoses pertaining to syphilis made in these two hundred eight cases, is as follows:

1. Latent syphilis	105 cases—50.49%
2. Central nervous system cases:	
(a) Tabes	35 cases
(b) General paresis	7 cases
(c) Tabo-paresis	5 cases
(d) Meningo-vascular syphilis	5 cases
(e) Cerebral vascular syphilis	7 cases
	59 cases—28.36%

3. Cardiovascular syphilis, including aortic aneurysm, aortic regurgita- tion, definite aortitis, and coro- nary stenosis	24 cases—11.54%
4. Secondary syphilis	13 cases— 6.25%
5. Congenital syphilis	7 cases— 3.36%
6. Primary syphilis	6 cases— 2.90%
7. Tertiary skin syphilis	4 cases— 1.92%
8. Tertiary syphilitic hepatitis	2 cases— .96%
9. Syphilitic periostitis	2 cases— .96%
Total	222 cases

The total of two hundred twenty-two cases totaled from the lesions as against the actual two hundred eight cases of syphilis reveals the fact that in fourteen cases, there was a major double lesion, the usual combination being a central nervous system lesion and a cardiovascular lesion. The latent cases were those in which there was no distinctly recognizable clinical lesion when the patient was seen. Many of these cases in the course of further time would develop clinical lesions of syphilis, especially if untreated.

A series of cases comparable to that of this paper has been presented by Hadley² of Washington, D. C. Seven thousand consecutive office patients were subjected to routine serology tests of various kinds, with one hundred sixty-five positive reactions, or 2.35 per cent; this figure, it will be noted, compares rather closely with the 2.08 per cent quoted above. Since both percentages are derived from similar types of practice, considerable significance can be drawn from the figures, at least as regards the type of patient seen in private practice.

Kelly and Short³ have reported the results of serology tests in nearly 16,000 non-selected cases, chiefly of insurance policy-holders. Here there were 1.77 per cent positives, with .96 per cent doubtful. This group, in common with those mentioned previously, would represent a type above the general average financially and socially.

Various estimates of the prevalence of syphilis in the general populace have ranged from .28 per cent to ten per cent. The incidence in negroes, of course, is much higher than in whites. Beck⁴, reporting on syphilis in Delaware, and basing his figures on a variety of sources, estimated that less than two per cent of the white, and about thirty per cent of the colored population of that state have syphilis. Usually the discrepancy is not that marked; the incidence of syphilis at the Louisville City Hospital over a ten-year period, as reported by Humphrey¹, et al., was 4.1 per cent for white patients, and 13.1 per cent for colored. They found that cardiovascular and neurosyphilis were much more prevalent in men, and also that there was a very high relative incidence of cardiovascular syphilis in negro men, with a corres-

pondingly high relative incidence of neurosyphilis in white men.

Syphilis in colleges has received considerable attention, but figures are not very accurate, because many of the series have not been compulsory. It is reasonable to assume that those individuals knowing of, or suspecting to have, a positive test, would deliberately avoid being tested. This must be kept in mind in considering the figure of 1.99 cases per 1,000 for white students, as quoted by Tumbleson⁶. Furthermore, most tests are done on students of the freshmen classes.

Such matters as false positive tests, doubtful cases, errors inherent in statistical compilations, etc., all merit serious consideration as factors involved in the correct evaluation of the prevalence of syphilis. They are, however, outside the scope of this paper; suffice it to say that careful serological testing plus careful clinical examination will enable a correct diagnosis to be made in nearly all cases of syphilis considered as individual problems.

SUMMARY

1. In a series of 10,000 consecutive patients seen in the private practice of internal medicine, the incidence of syphilis was found to be 2.08 per cent.
2. Approximately one-half of these cases of syphilis were in a latent stage, and the diagnosis of syphilis would not have been made without the aid of routine serology tests.
3. A negative blood Wassermann was present in eleven cases of advanced clinical syphilis, or 5.8 per cent of the total number of syphilis cases.

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We must recognize the fact that tuberculosis begins in the human body when the tubercle bacillus is first lodged in the tissues and the whatever occurs subsequent to this is largely beyond our control. The disease may be interrupted permanently by the body's defense mechanism soon after it begins; it may be interrupted temporarily on numerous occasions but eventually may reach its ultimate goal by destroying parts or even the life of the body. J. A. Myers, Myers, M.D., Annual Meeting, National Tuberculosis Association, 1940.

SALICYLATE THERAPY IN ACUTE RHEUMATIC PERICARDITIS WITH EFFUSION

REPORT OF A CASE*

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This case is presented as an interesting case report because of some unusual features present, and as additional evidence in support of the use of salicylates in the treatment of acute rheumatic pericarditis with effusion.

Wide differences of opinion exist among medical men today in the use of the salicylates in the treatment of rheumatic fever and its complications. In the United States salicylate therapy has been used chiefly in acute rheumatic arthritis. In Europe, and especially in France, certain investigators regard the salicylates of definite value in cardiac complications. Paliard and Badenand¹ have reported the rapid disappearance of symptoms in rheumatic fever with pericardial involvement by the use of salicylate therapy. Likewise, Cassoute² and his co-workers have noticed a rapid resorption of fluid and a marked improvement in the symptoms of the rheumatic effusion following the use of this drug. Danielopolu³ advocates the use of fifteen to thirty grains of sodium salicylate daily in the first few days of acute rheumatic fever in order to prevent cardiac complications.

In South America there is an increasing tendency to use huge doses of salicylates in all types of rheumatic complications. Funes⁴ recommends an initial dose of eight to ten grams, increased to fifteen to eighteen grams daily in moderate cases, or twenty to thirty grams daily in severe cases. Canepa⁵ reports favorable results in the use of the duodenal tube in administering a maximum dose of twenty to twenty-five grams daily in severe cases, and twelve to fifteen grams in the presence of toxic symptoms. He favors the duodenal tube because of the better absorption obtained with early maximal effect, and the absence of gastric symptoms. Bertani⁶ favors the giving of salicylates in large doses per rectum combined with daily intravenous injections of about two grams. Bullrich⁷ and Velazquez⁸ report great success in the use of polysalicylates in isotonic solution given per rectum with the Murphy drip or by the subcutaneous route. They recommend the following proportions:

* From the Student Health Service; Kansas State College, Manhattan, Kansas.

Sodium salicylate	15.0 grams	To these proportions is
Potassium salicylate	1.7 grams	added 1000 cc. of dis-
Calcium salicylate	1.7 grams	tilled water to make an
Glucose	10.0 grams	isotonic solution.

In this country many conflicting reports exist regarding the importance of using the salicylates in the treatment of this disease. Coombs⁹ reports favorable limitation of the extent of the cardiac lesions with the administration of salicylates. White¹⁰ believes that the drug has a certain specific control of the rheumatic infection. Conversely, Murray-Lyon¹¹ believes there are no beneficial effects of the salicylates in the prevention or treatment of rheumatic pericarditis. Hanzlik¹² also shares this view and states further that the action of the salicylates is antipyretic and analgesic and can be attained equally as well with the use of aminopyrine and cinchophen. Similarly, Miller¹³ and Master¹⁴ state that the salicylates do not reduce the frequency of cardiac complications of patients with rheumatic fever.

Leech¹⁵ conducted an interesting piece of work with sixty-seven children having potential rheumatic heart disease. He gave each child twenty grains of acetylsalicylic acid daily for six months and compared their progress in body weight, improvement in heart rate, general bodily comfort, and actual physical capacity with a control group of seventy-nine children. In his conclusion he says, "The analysis as recorded seems to show that there is a definite advantage in giving daily rations of salicylates to children who represent actual or potential instances of rheumatic heart disease."

Rathe¹⁶ in a review of ninety-five cases of rheumatic heart disease recommends large doses of acetylsalicylic acid to be given with sodium bicarbonate or magnesium oxide. Lyon¹⁷ and Robey¹⁸ also advocate early treatment with salicylate therapy, and Taussig¹⁹ believes the salicylates are of great value when combined with magnesium carbonate in equal quantities. Recently, Boas and Ellenberg²⁰ have reported the use of salicylate therapy in twelve cases of rheumatic pericarditis with effusion with complete success. In their report they state, "Since employing the medication we have had no occasion to aspirate the pericardium of any patient with rheumatic pericarditis."

CASE REPORT

The patient, an engineering student, twenty-one years of age was admitted to the College Hospital on April 2, 1940, because of marked epigastric pain and a temperature of 100 degrees F. His past history revealed whooping cough at the age of three years, scarlet fever at four, measles at fourteen, and chickenpox at sixteen years of age. A tonsillectomy had been performed at the age of eleven. Except for these diseases his general physical health had otherwise been good until the onset of his present illness.

At the time of examination his only complaint was a severe, continuous epigastric pain of twenty-four hours

duration. Although his skin had a somewhat ashy gray appearance, he did not appear acutely ill and was not excessively uncomfortable. Palpation elicited marked tenderness and rigidity of the entire epigastrium which was increased with deep inspiration. The area below the right costal margin was equally tender and the presence of a liver edge was difficult to determine because of the marked rigidity present.

Further examination revealed a markedly irregular pulse of 104 beats per minute which disappeared with each inspiration (pulsus paradoxus). The blood pressure was ninety systolic and sixty diastolic. The heart tones were quite distant but no pericardial friction rub was heard. Breath sounds were suppressed in the anterior left chest and a large area of cardiac dullness was discovered well beyond the mid-clavicular line. There was also a moderate distension of the veins of the neck.

The temperature was 100 degrees F. Examination of the urine was negative. The hemoglobin value was ninety-one per cent, the erythrocytes numbering 4,910,000, and the leucocyte count was 18,200. The differential cell count showed eighty-four per cent neutrophils. The sedimentation rate was moderately increased to 17.0 in one hour. Blood culture, all agglutination tests, and Wassermann were negative. A portable chest film showed a markedly enlarged heart shadow measuring twenty-two cm. in the transverse diameter. The electrocardiogram showed a slight elevation of the R-T segment with an alteration of the P-R interval in all leads compatible with an extreme toxemia (Fig. 1). The venous pressure was fifteen cm. of blood.

SUBSEQUENT COURSE AND TREATMENT

The diagnosis was an acute rheumatic pericarditis with effusion and the patient was given twenty grains of sodium salicylate and an equal quantity of sodium bicarbonate every four hours. The average daily dosage varied during the immediate treatment period, but a maximum dose of 120 grains was maintained as constant as possible, regulated by symptoms of salicylate intoxication chiefly manifested by buzzing and ringing in the ears. In addition, massive doses of vitamin B₁ were administered both orally and intravenously. The protein of the diet was increased and fluids were restricted to 1500 cc. daily.

On the sixth day after admission to the hospital and seven days after the original onset of the pain in the epigastrium, a very loud to and fro friction rub was heard. On this same day there was a noticeable improvement in the quality of the pulse, less epigastric tenderness and rigidity, a diminution of the congestion of the veins in the neck, and the twenty-four hour urinary excretion exceeded the fluid intake by 1200 cc. (Fig. 4).

There was a gradual decline of the temperature curve and the pulse rate which reached normal proportions on the fourteenth day of hospitalization, and ten days after the salicylates were started (Fig. 4). The chest film showed a reduction in the size of the cardiac shadow to fifteen cm. in diameter, and the electrocardiogram was consistent with the clinical findings of a pericarditis with effusion (Fig. 2). The patient continued to improve on salicylate therapy with a gradual complete disappearance of his physical signs and symptoms. Approximately seven weeks later the chest film showed a return to normal of the heart shadow. An electrocardiogram taken here on September 20, 1940, revealed a return to normal complexes (Fig. 3).

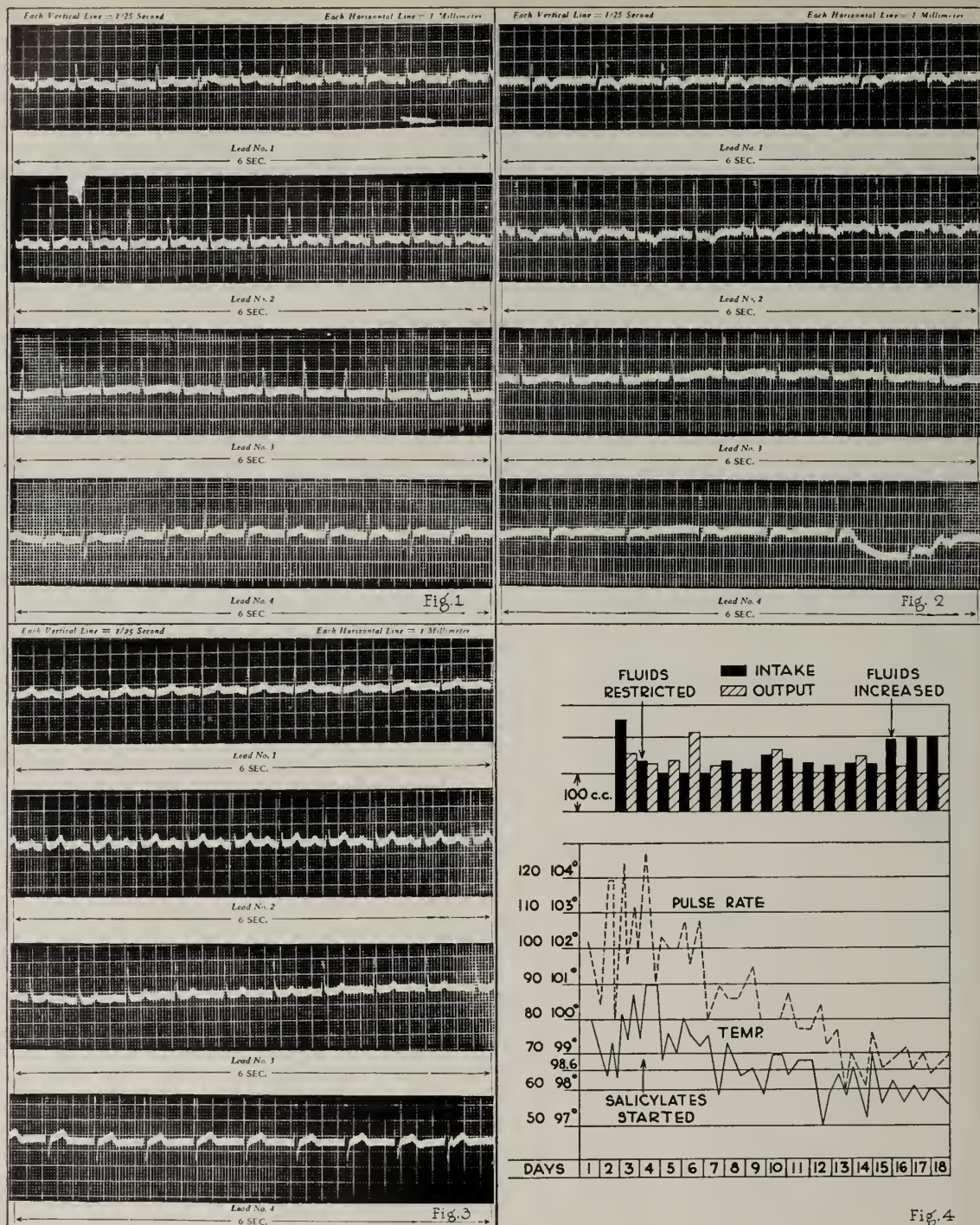


Fig. 1. Electrocardiogram at time of first examination showing an alteration of the P-R interval in all leads, especially in lead IV, indicative of an extreme toxemia. Fig. 2. Electrocardiogram approximately two weeks after the onset which demonstrates an insufficiency of the entire coronary circulation consistent with the clinical findings of a pericarditis with effusion. (Note reversal of T waves in all leads.) Fig. 3. Normal electrocardiogram taken approximately six months after the discovery of the effusion. Fig. 4. Chart showing the effect of the salicylates on the temperature curve, pulse rate, and daily fluid excretion.

DISCUSSION

The important question of draining the excess pericardial fluid was a primary issue in this case, particularly in view of the very extensive effusion.

After much consideration a paracentesis was not performed because of the absence of a respiratory embarrassment, and the accompanying signs and symptoms which indicated that a serous effusion was

present rather than a purulent one. We further concluded this to be on a rheumatic basis and promptly instituted the giving of maximum doses of sodium salicylate with sodium bicarbonate, and the massive administration of vitamin B₁. This rationale proved to be effective with the gradual decline of the temperature curve and the pulse rate, and a reduction of the effusion as observed on the x-ray films. There was never any involvement of the joints during the illness.

It would seem to indicate from these findings that a trial administration of maximum doses of salicylates, in the absence of other known causes of pericardial effusion, may be a distinct benefit in the treatment of similar cases, especially since rheumatic fever plays such a prominent role in the etiology of this condition.

It is interesting to note that this case showed only one predominant, subjective symptom, marked epigastric pain, which in itself had a tendency to make us more suspicious of some upper abdominal pathology. In most cases of acute pericarditis the pain usually occurs in the chest, predominantly in the precordium, and frequently is referred to the left shoulder and arm.

Another interesting case of referred pain which parallels this case report was cited recently by Baila²¹ in Argentina. His case was that of an eleven year old child with a similar onset of pain occurring, however, in the right lower quadrant which was diagnosed prior to hospitalization as an appendicitis. Later, further investigation revealed the signs and symptoms of a primary rheumatic pericarditis with effusion, and the x-ray films showed a greatly enlarged cardiac shadow, as in our case. An electrocardiogram revealed a similar reversal of the T waves in leads I and III. His treatment consisted of daily administration of sodium salicylate given per rectum (eleven gms.) and intravenously (one gm.). There was a prompt reduction of the temperature and pulse, and a marked decrease in the cardiac shadow within twenty days with a complete return to normal in the size of the heart shadow and a normal electrocardiogram two months later.

Further unusual features of this case include the absence of a pericardial friction rub and signs of a respiratory embarrassment which would be expected with a cardiac shadow measuring twenty-two cm. in the transverse diameter. The normal cardiac shadow measured 9.5 cm. in the transverse diameter as demonstrated on a previous routine chest film taken over one year before. It is significant that a very loud pericardial friction rub occurred on the sixth hospital day and continued for approximately four days. The presence of a pericardial friction rub is

conclusive evidence of an inflammatory process involving the pericardium, yet it is heard in less than twenty per cent of the cases known to have a pericardial involvement. Many cases of acute pericarditis are overlooked because of the absence of this clinical phenomenon.

In making a differential diagnosis in this case we were confronted with the possibilities of some upper abdominal pathology causing a vasomotor collapse, a possible pleural effusion with diaphragmatic irritation, or a massive pericardial effusion. After a final diagnosis was made we were impressed with the remarkable compensatory powers of the heart and pericardium in the face of the accumulated fluid as evidenced by the almost complete lack of symptoms, and the comparative ease of the patient. This condition was undoubtedly a gradual affair over a number of days with no symptoms occurring until twenty-four hours before examination, and then with only the complaint of an upper abdominal distress which was not prostrating in character and certainly not suspicious of a cardiac affair.

In conclusion, we believe that we are justified in stressing the importance of examining the cardiovascular system in young individuals to include the pulse, blood pressure, and chest when upper abdominal findings are present. This is especially important in institutions such as this where a great number of cases are seen daily including a large group which are tentatively diagnosed as an acute gastro-enteritis.

SUMMARY

A case of primary rheumatic pericarditis with effusion is presented to emphasize certain features of diagnosis, and to further establish the importance of the salicylates as a specific chemo-therapeutic agent.

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PEDOLOGY AND ITS POSSIBILITIES

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Pedology has been defined as "That branch of pediatrics in which the physical and mental defects of development are especially studied and treated by the physician."

Many controversial discussions on this subject have arisen in the past owing to the multiplicity of theories as to what should constitute the basic facts in the study of pedology; also many movements have been promulgated by laymen, attempting a task in which they are wholly unfitted by lack of training and experience to successfully interest the public or the medical profession sufficiently to get behind and champion such a worth cause; or to stimulate a more thorough and fuller investigation of the causes and treatment of feeble mindedness and other mental diseases of childhood.

It is quite evident that many children do develop mental defects at an early age, producing retardation and derangement of the cerebral centers, and I must say with much regret, that many of these cases are frequently overlooked, or neglected until it is possibly too late to accomplish any beneficial results from any form of therapy.

This subject has a very important field; one in which much good may be accomplished for the unfortunate defective, backward child.

Men who have had speacialized training, and who are familiar with the many factors involved in the developmental activities in defective, deficient and backward children, should make careful and scientific study of the prophylaxis, etiology and treatment of all these cases, and thus perform an important obligation to society and humanity.

In early life, while the brain is soft and plastic, much may be accomplished for these defectives; and

while we all recognize the great benefit to be derived from the proper use of heliotherapy, rest, exercise, and fresh air; yet, it is a mistake to depend upon them as a curative agent, especially to overcome a disease which has for its basic pathological foundation the overstimulation, or dysfunction of the ductless glands.

Much literature has been written on this subject in the past regarding the influence of the internal secretions upon the psychic development of the child.

Falta¹ says, "We must accept the ductless glandular system for itself alone; the ductless glands as vegetative organs together with the nervous system regulate their functions."

McCready² remarks, "While our knowledge of the normal action of the endocrines is still somewhat hazy, yet they are found to preside in some manner over certain correlations of the body, that the majority of the feeble-minded children in which backwardness is not traceable to accidental or purely environmental causes, presents evidence of ductless gland irregularity with resulting growth disturbances in the developing embryo, especially in the weeks of foetal life when the ductless glands begin to appear in the cells of which they are composed grow imperfectly and defective development ensues."

Harrower³ believes, "The internal secretory system exerts an influence on anomalies of growth and organic metabolism."

Lombroso has given us a vivid picture of mental derelicts, "Many of these children are born malformed both externally and internally through chemical unbalance of their mother's blood and lymph during pregnancy, which is often due to disturbances of the ductless glands." These unhappy individuals, which show gross defects of such disturbances, are the typical criminals of Lombroso.

Dr. Hall⁴ says, "All great criminals have given proof of perversity in their youth, especially at the age of puberty, and sometimes even before."

Judge Waite⁵ is of the opinion that the outlook for girls and women of the feeble-minded class is always very discouraging. "They are never able to support themselves. If discharged they at once return to vicious or criminal life. They are certain to become sexual offenders and to spread venereal diseases, or to give birth to children as degenerate as themselves. Their numerous progeny are certain to become public charges as diseased or neglected children, imbecils, juvenile delinquents; or later as adult paupers and criminals."

Henderson⁶ says, "We may safely make the generalization that most all criminals are physically and mentally inferior: the mental subnormal conditions is casually related to some anatomical and physi-

cological defect which requires no argument. It is a common place science."

Dr. Robertson⁷ remarks, "It is only recently that a distinct awakening to the danger from feeble-minded or mental defectives having criminal tendencies has been awakened. The struggle for existence which is becoming so much more severe causes these defectives to commit crime."

It is quite obvious that dwellings in the crowded areas of commercial districts soon become undesirable; age and depreciation soon follow under such circumstances and become unprofitable investments, producing poor housing conditions. There are also many things which contribute to the undesirableness of such areas for homes; such as smoke, noise, offensive odors and general unattractive surroundings; the "slum" district. It is here that we find the greater number of delinquents and associates in crime.

Dr. Richards⁸ says, "Underneath every crime is some kind of incompetence, and underneath incompetence is some kind of physical defect, either inherited or acquired."

Dr. Henderson⁹ quotes Tarde as follows, "The delinquent is before everything a sick man; insufficient nourishment of his nerve centers, badly nourished brain, misfortune and poverty."

Some writers have contended that behind every case of crime; heredity, or environment has played an important part in its production. Dr. Hall¹⁰ says, "Heredity plays a part in different ways. It is now generally accepted that every individual in its development from infancy to maturity repeats the history of its race.

During the pre-adolescent period, namely from about ten to fifteen in boys and about nine to thirteen in girls, the youth is repeating in his own personal development the age of barbarism of the race. It is also during this period that he is restive under restrictions and restraints of our modern order. His whole soul craves freedom and rebels against confinement of the school or the shop. The call of the wild comes to him with a hundred voices and we must not be surprised if he listens to these calls and responds.

There are those who do not believe in heredity, yet we must confess that there is more or less convincing evidence of heredity, plus environment, in the evil effects of relationship as a definite contribution to delinquency and crime, and as we study this subject more thoroughly we are soon impressed by the predominating evidence in which family relationship and its underlying effects upon the child are clearly demonstrated, and these are important in the study of the backward child. The subtle agencies do far more harm to the adolescent and the youth than

many are willing to believe. Although separation and divorce of parents may not be the chief and most important causes of child delinquency, yet it is quite presumptive that frequent conflicts, fits of temper, brawlings and exasperating quarrels between parents in the presence of children may be an exceedingly far reaching cause of delinquency. Such emotional conflicts leave a distorted and lasting impression on the mental and emotional equilibrium of the child.

Healy and Bromer¹¹ state, "It seems to us from our experience that if one is looking for what the home life either positively or negatively through directly bad influences, or through lack of good influences makes for inability to withstand outside temptations, one must consider first and foremost the mental or spiritual aspects of home life. The subtler aspects of human situations are quite vastly more formative than anything that can be more subjectively observed or enumerated."

This statement made by Healy and Bromer has been substantially confirmed by statistical data presented in detail case studies, and such case histories reveal convincing evidence that the subtler relationships between members of the family are often significantly involved in the child's delinquent behavior.

Burgess¹² says, "That the family is more than a legal formulation or aggregation of individuals. It is a dynamic unity, the structure and vitality of which depends upon the process of interaction between members. Such dynamic elements as attitudes, gestures, and personalities of the members of the family seem to constitute the important determining social factors in the early personality development of the child."

These social relationships begin in the home in earliest infancy and continue as the most potent forces in the whole life of the individual.

It is these relationships, attitudes and gestures between parents, brothers and sisters which give form and direction to the child's love, to his hate, to his fears. It is out of these relationships that crippling jealousies and envies may emerge, crippling not only his happiness but his efficiency, and not only in the present but in the future.

A child in his behavior generally finds his models in the accustomed behavior patterns first of the other members of the family, then of the adults among his relatives whom he admires, or in the neighborhood, or school. Some of his companions serve as his models. Also from these patterns, which often influence him both directly and indirectly, he acquires his attitude toward authority. For instance: if his parents are critical of the school and his teachers, he reflects this attitude by rebellion or antagonism.

If he feels that his parents are fair in their judgments of others, or of his own mistakes and misbehavior, the child gets an attitude of fair play which he carries on in his relations with the people he meets. Whether he considers the rights of other people depends more upon his experience in his family than upon oft-repeated precepts. His attitude toward work may be a repetition of that of his parents. Even his sense of humor is largely dependent upon the family mood. In ways of gaining his own ends he is much influenced by patterns set by other members of the family. In fact, emotional reaction patterns are constantly before him in the family life and his habits of reaction are influenced inevitably by those moods.

Students of pedology are convinced that a large number of youthful criminals are initiated into crime at a very early age. Case histories compiled indicate conclusively that many inmates of penal institutions can be traced back to charges occurring in early childhood and during the adolescent period. They are the sum total of growth development under emotional strain and duress.

Goddard says¹³, "We are coming every day to a larger group of people of whom we call feeble-minded."

The Memoirs of The National Academy of Sciences¹⁴ give us the following facts, "In the selective draft during World War tests were applied to about 1,700,000 drafted men in various training camps. Most of these men were between the ages of twenty-one and thirty-one years, some between nineteen and twenty-one. It was stated approximately ten per cent of the enlisted men are found to be of the mental age of ten years or below and considered unfit for military service."

Many eminent writers of the past, and also of the present, recognize the criminal as a sick man, one who possibly is of the defective, deficient or feeble-minded type, who no doubt in his early childhood exhibited perversity, or some abnormality, which was passed on unnoticed or unheeded; but had he received the proper care and consideration, the proper examination and treatment by a competent physician, he might have made a useful and trusted citizen.

I am truly convinced there are many criminals who are victims of a disease that had its conception in early childhood; some derangement of the cerebral centers, followed by feeble-mindedness which we will be pleased to classify as defective or deficient, and that these individuals might have been cured of this affliction and assisted to grow to manhood or womanhood and make useful citizens. I am also convinced that our present judicial system of handling the usual criminal is wrong. I believe it would

be better to have fewer penitentiaries, and more hospitals; fewer courts of justice and more medical commissions; more scientific laboratories to examine these unfortunate derelicts of society—our forgotten humanity.

It is truly an unfortunate thing that our present system apparently views all men alike; whether they be made of iron, wood or clay, the same form of action is used. The same procedure is invoked to correct his moral defects. All these methods are expected to cure his malady, and to react the same way to legal punishment. Our criminal system is inclined to view every killer as sane who is not a howling, roaring madman.

The short, sham, deceptive interviews with a prisoner in our hold-overs, and jails, are so often a farce, and only a make believe to pull-the-wool over the eyes of the public to satisfy the people by suddenly calling some physician to make a mental examination and to pose as an expert witness. It may also be possible that this same physician has never had the training to qualify him as a psychiatrist and would not know a case of paranoia from one of general paresis. Such examinations are an insult to the profession and to medical science.

I feel that it is safe to say that it has been the experience of every resident physician of our hospitals for insane to have examined and treated many incurable insane, and have found them to be very cunning, and have the ability to execute some of the shrewdest and most daring tricks to escape from their incarceration; and who also would manufacture the most skillful alibi's for their misconduct in breaking hospital rules. They may show shrewdness in many ways, yet they are wholly without the power of restraint; and possess but little ability to grasp moral values, or to inhibit from acts against the law and the lives of others.

Dr. Schlapp¹⁵ has, I think, demonstrated clearly to the satisfaction of most of his readers the definite effects of the endocrines as a fruitful source of abnormal behavior. His thorough, painstaking research work at the Post Graduate Medical School and Hospital, New York, has proven beyond a doubt that these outward peculiarities are indicative of an internal derangement of the formative processes of the brain and other parts of the nervous system.

"Many writers of the past have made use of the following terms interchangeably, viz., deficient and defective. It is at present quite apparent that one kind of mental sufferer owes his trouble to disturbances of the formative process in the cells at an early stage of development of the foetus, with the result that certain parts of the central nervous system, or brain are either totally absent or partially formed. The other

type has suffered a formative upset either in foetal life or of a less severe character, with the result that the brain is completely formed, whereas, the glands and certain neuron groups have been malformed or underdeveloped. In the first instance there is an absence, or lack of brain mechanism, in other words a deficiency. This classification includes idiots, imbeciles and half-wits, low and high grade morons and their types—the whole feeble-minded family. When subjected to the common psychological tests all the members of this group show low mental ages or low intellectual quotients. They will accordingly be referred to as deficient, or the formative type, and their trouble termed deficiency.

Many mental sufferers belong to the second or defective type. Their brains are fully, or normally, developed. They show high intellectual quotients, are intellectually sound and nimble witted, sometimes display talent and occasionally marked ability, or even genius. Instead of deficiency these types display either subtle or gross faults in the mental and nervous mechanism which vary in intensity to their surroundings and situation. These faults or misfunctions are due to disturbances of the glands. Persons belonging in this category uniformly display a lack of inhibition, which is to say an inability to control their actions. They are accordingly called abnormally unstable since it is the emotional mechanism in the brain which is affected. The fundamental difference between these people and the feeble-minded is there is no absence of parts to do their work, but defective function. Consequently, this type is known as the functional type."

Feeble-mindedness in which the seeds of a vast amount of criminality repose is constantly on the increase among us because mothers, both foreign and native born, are being disturbed nervously, emotionally, and glandularly by modern environment, by conditions under which women live and labor by the stresses, the speed, the shock and the compression of existence. The result of this exposure of our procreatrices may be seen most clearly in gross idiots and the imbeciles born of women, otherwise sound and strong, who have been emotionally disturbed and therefore gladdly unbalanced during the all important months of gestation.

Much water has passed under the bridge in the past decade, and the crude, fantastic ideas advanced by Brown-Sequard and their loyal followers have ripened into a golden fund of knowledge, well established, placing endocrinology upon a rational basis, furnishing definite indications for the administration of many glandular substances to definite diseased conditions. To again quote Dr. Schlapp^{14,15}, "We have observed cretinous imbeciles in which the

formative process has been corrected because of the absence of the necessary chemicals which stimulated cell growth. We have also seen that when the necessary chemistry is supplied artificially, growth is resumed and such cretinous children develop normally."

Organotherapy is not a panacea in the treatment of feeble-mindedness, or mental defectives. Those who are looking for a specific in glandular therapy are likely to be disappointed. There are however, many cases which have responded admirably to its therapy, and brilliant results have been achieved by their use.

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ARMY MAKES 8500 GALLONS OF TYPHOID VACCINE

Typhoid vaccine production is big business at the Army Medical School in Washington. During the fiscal year, recently closed, the turnout was 33,500,000 cubic centimeters, or about 8500 gallons, representing more than an eightfold increase over the previous year. This is enough vaccine to provide over 8,000,000 "triple-shot" courses. By making its own vaccine, the army saved the government \$1,540,000 over what it would have cost at the regular market rate.

Besides giving all soldiers in the army protection against typhoid, the medical department is furnishing vaccine to other government departments, including the U. S. Public Health Service, the navy, the Civilian Conservation Corps, the Department of Justice, the Indian Service, the Veterans' Administration, the Government of Puerto Rico, and many others. Stock culture for the vaccine has also been furnished on request to other nations in the Western Hemisphere.

All the vaccine is based on germs taken from the body of one man, an immune typhoid fever carrier who lives in the Panama Canal Zone, and is kept under constant supervision by army physicians. The cultures are preserved in glass tubes, superfrozen at a temperature of 108 degrees zero, and sealed in a partial vacuum. In this state the cultures can be kept for long periods. The laboratory where the vaccine is made is the largest and most modernly equipped of its kind in the world.—Science News Letter.

President's Page

To The Members of The Kansas Medical Society:

With the annual meeting in the offing, be assured the program is taking form and that the variety of subjects to be presented by leaders in their chosen fields will appeal to all the profession. Some new innovations will be presented adding zest in presentation of subjects of interest in a brief but effective manner. We are indebted to the Sedgwick County Medical Society for its untiring efforts in arranging a program of excellent scientific value to all.

Theirs has not been an easy task in this time of war, when the entire profession like all others is concerned with the successful and speedy prosecution of all out activities to bringing about a successful termination of hostilities and a lasting peace.

Kansas is doing her duty in response to the military needs of the armed forces in medical personnel and there is ample evidence she will continue to maintain a position, well up the line of all the states. The medical men of Kansas, it is certain, will not be at any time unmindful of civilian needs and as our ranks become depleted and greater demands are made on those of us remaining at home, we will broaden our fields of professional service to the limit of personal endurance, insuring adequate medical care to the entire state and thereby meriting the confidence and esteem of those we serve.

Sincerely yours,

Clyde O. Blake M.D.

EDITORIAL

ANNUAL SESSION

The 83rd Annual Session of the Society is to be held in Wichita on Monday, Tuesday, Wednesday and Thursday, May 11, 12, 13, and 14.

The Sedgwick County Medical Society, as host for the meeting, has been active throughout the past year in planning an interesting and instructive program. Conditions resulting from the war have not make this task an easy one and the physicians of Sedgwick County are to be congratulated for the excellent arrangements they have made.

The program will include: Dr. Frank H. Lahey, President of the American Medical Association, of Boston, Massachusetts; Dr. Charles W. Mayo of Rochester, Minnesota; Dr. Alan Brown of Toronto, Canada; Dr. W. D. Stroud of St. Louis, Missouri; Dr. H. R. Hildreth of St. Louis, Missouri; Dr. Joe V. Meigs of Boston, Massachusetts; Dr. Paul O'Leary of Rochester, Minnesota; Dr. John M. Shea of Memphis, Tennessee, and Dr. Cyril M. MacBryde of St. Louis, Missouri, as guest speakers. These speakers and others will present a complete and informative program on numerous phases of medical practice. The scientific exhibit section will be one of the largest in the history of the Society. Reservations have been received to date from forty technical exhibitors. The other usual events and several new events have been arranged.

Dr. Frank Lahey will be the guest speaker at the annual banquet, which will be held on Wednesday, May 13. His topic will be "Medical Problems of Today."

It is realized that various conditions presently affecting medical practice will make it difficult for many physicians to be able to attend the 1942 annual session. It is also true, though, that all physicians, whether they will assist their country in the military forces or at home will have need to be as completely familiar as possible with all that is new and all that is old in the practice of medicine. Likewise, many physicians will be called upon to engage in forms of practice which they have not recently engaged in and in which refresher courses will be of particular assistance to them. The 1942 annual session will provide an excellent opportunity for that purpose. An excellent contribution will be made to military and civilian needs if every Kansas physician attempts to spend as much time as he can at the Wichita meeting.

A detailed description of the program will be published in the April issue of the Journal.

PLASMA

Blood plasma has recently received considerable attention and since the advent of the war there has been a need of a thorough understanding of its use. Plasma has been advantageously used and recommended by various writers in a multitude of conditions which require an increase of fluid or protein in the peripheral blood. Its most extensive and successful use, however, has been in the treatment of shock, the essential feature of which is a hemoconcentration produced by a loss of fluid volume. While there is considerable controversy as to the mechanism of the loss of fluid (plasma) from the circulating blood there is little doubt that its loss is the biggest factor in producing the shock syndrome.

The most rational use of plasma is in the treatment of burns, shock, or of secondary shock not associated with hemorrhage but it also has been found that it is just as efficacious as whole blood in the immediate treatment of shock due to hemorrhage providing the blood loss is not more than fifty per cent of total and it is far more important to restore the fluid volume than to restore the erythrocyte concentration. The feature of plasma, plus the fact that it can be stored and ready for immediate use has made it our most potent weapon in combating shock.

It has long been said that the best treatment of shock is its prevention but failing in this our next best course is to begin treatment as early as possible. The classical signs of thready pulse and low blood pressure are usually late signs, particularly when the impending collapse is due to hemorrhage.

Certain laboratory tests aid in the early diagnosis of shock and to some extent help to determine if plasma, whole blood, or other fluids should be administered.

The hematocrit test consists of centrifuging oxygenated whole blood at 2,500 R.P.M. for twenty minutes in a special graduated tube in order to determine the volume percentage of cells and plasma. In the male the cell volume is normally forty-six per cent and the plasma volume fifty-four per cent while in the female the cell volume averages forty-one per cent and the plasma volume fifty-nine per cent.

Plasma proteins give the best indication of osmotically active protein level of the blood. The normal range of plasma proteins is 5.9 to 7.9 per cent of plasma weight and the average is seven per cent. Plasma proteins can be determined by direct chemical analysis or they can be estimated accurately and simply by determining the specific gravity of the plasma with a densimeter.

The red blood cell count and hemoglobin determination are of considerable aid, the result correlating quite closely with the hematocrit test.

In shock without hemorrhage such as burn shock the hematocrit determination shows a marked increase in cell volume, this sometimes being as high as eighty per cent. The plasma proteins usually drop significantly and the R.B.C. and hemoglobin are increased.

In shock due to hemorrhage the cell volume is low and may drop to ten per cent in severe blood loss. The plasma proteins are also low. The red count and hemoglobin is at first unchanged and then becomes lowered as the dilution of blood from intracellular water begins.

When the plasma proteins are normal or high the administration of glucose or saline will usually be sufficient but when the proteins are low, fluids containing proteins will be necessary to prevent the recurrence of shock. A single 500 cc. intravenous infusion of plasma will raise the circulating protein ten per cent in the average 140 pound individual, while whole blood will raise the proteins seven per cent.

It can readily be seen that whole blood is not the best fluid to give when the cell volume is already considerable increased over normal because while it may at first cause a relative dilution it may later add to the hemoconcentration as some of its plasma is lost in the tissues. In these cases plasma is much more satisfactory as it affords a better dilution and yet retains its osmotic pressure effect.

In preparing plasma the blood is drawn as for an indirect transfusion. It is not necessary to type the donors but they should be fasting and with a negative serology.

There are two general methods of separating plasma from cells in citrated whole blood. One method consists of centrifuging the blood after it has been chilled for twenty-four hours, and in the other, or sedimentary method, the blood is allowed to stand for twelve days and then the plasma is decanted off. The first method requires more expensive equipment but is superior to the latter in that there is less hemolysis and less diffusion of potassium from cells to serum.

Plasma is furnished in three forms: liquid, frozen, and dehydrated. Liquid plasma is simply kept at forty C until ready for use. Frozen plasma is thawed slowly to ice box temperature over a period of several hours, this time being necessary to prevent protein precipitation. Dehydrated plasma may be dried from the liquid or from the frozen state, when from the latter it is called lyophile plasma. Dried plasma is simply mixed with pyrogen free water and

it is ready for use in a few minutes. This is the type used by the Army.

It is advisable to put all plasma through a No. 200 wire mesh filter before use as deaths have occurred from plugging of brain capillaries by precipitated fibrin from unfiltered plasma.

SECOND AMERICAN CONGRESS ON OBSTETRICS AND GYNECOLOGY

The Board of Directors of the American Committee on Maternal Welfare has planned to hold the Second American Congress on Obstetrics and Gynecology in St. Louis, Missouri, on April 6-10, 1942.

This world is engaged in a most devastating war which is destroying life at a greater rate than in any war in history and at the same time is quite likely to produce more chaos among the civilian population. This committee is and has been for many years engaged in a war to conserve life at its fountain head through the protection of mothers and babies. Our national defense and war effort is enhancing to an unbelievable degree the problems associated with maternal welfare, for instance, how to give mothers adequate care with a personnel being more and more restricted in numbers as well as in specialized training. How to maintain the high level of care given in the past in the face of a sharp increase of the birth rate. These and a great many more problems are deemed of utmost importance in maintaining civilian morale, as well as the morale of men in the armed forces, by giving them the realization that their women and children are being adequately cared for.

In view of the many different groups involved in maternal welfare, the program is being arranged to embrace every group involved, that is, the medical profession, nursing profession, public health personnel, educators and administrators, in the hope that with all groups of people contributing mutually, that out of this Congress may come at least some of the answers to our many problems.

The Congress is being held in St. Louis, which is particularly convenient for middle western men. To be successful it needs very badly the support of every individual interested in any part of the maternal welfare problem and in return every individual is certain to receive much help from the internationally known authorities appearing on this program.

MEDICAL SCHOOL

TUMOR CLINIC OF THE UNIVERSITY OF KANSAS HOSPITALS*

MYCOSIS FUNGOIDES

The first case, E. S., from the Out-Patient Clinic, was presented by Dr. David Robinson, Jr., Surgical Resident.

Dr. Robinson: "The patient is a thirty-two-year-old colored male who first noted several nodules developing in his skin about three months ago. The one above his left eye gradually enlarged; suppurated, broke down, and ulcerated and then healed over in two or three months. Then he developed multiple nodules over his right eyebrow, which suppurated, broke down, and formed this large ulcerating lesion which will not heal. In November of last year, similar nodules developed over his shins and forearms. These were rather firm nodules and just beneath the skin. They are not painful. Some of the lesions are two to three cm. in diameter. Those over the shin have the appearance of healing ulcerations of the skin."

"The patient has never had a chancre and his Wassermann is not reported. His other studies, urinalysis, chest x-ray, and blood studies are all negative. His sedimentation rate was quite rapid, being twenty mm. in one-half hour."

"I took a nodule out of his forearm for a biopsy and had it cultured as well. The patient states that the arm, where the biopsy was performed has pained him a great deal. This morning there is swelling about the wound and on opening the wound edges, about one-half dram of yellow pus was drained out. It was questionable as to whether it was our technique or some other cause that resulted in this infection."

Dr. Harless: "Doctor Major, do you wish to say something about this patient?"

Dr. R. H. Major: "We did not have very much data for a diagnosis. As you know, there are a great number of possibilities. The first suggestion, by Dr. Max Allen I believe, was an infection with Hansen's bacillus. We made a slide of the ulcerative material and no acid-fast organisms were seen. We realized that the diagnosis would depend largely on

the laboratory reports, chiefly the pathologist's report. We also considered the possibility of mycosis fungoides which was one of the first diagnoses advanced, and tuberculosis was considered also."

Dr. Gordon: "Does the infection of Hansen's bacillus ever ulcerate?"

Dr. Major: "Yes, it does. I have not seen very many of these infections with Hansen's bacillus but I remember one case in Detroit where the patient had a very extensive ulceration of the leg which had been diagnosed previously as a varicose ulceration until he was finally brought into the hospital and a smear showed almost nothing but Hansen's bacillus. However, I think this diagnosis very unlikely here."

Dr. Mahlon Delp: "I thought your diagnosis of mycosis fungoides excellent, except for one thing, which is the short course which does not seem to be typical of the mycosis fungoides infection. We know that this patient's serology is negative as he has had two previous Wassermans which were negative. Except for this, we would be inclined to think it was a luetic type of infection or possibly tuberculosis, or the sarcomatodes granuloma. Then we also have to consider the possibility of some type of infection related to Hodgkin's Disease."

Dr. Harless: "Isn't it true that mycosis fungoides goes through four stages. First, the dermatitis or premycotic stage, second infiltration, third tumor formation or fungoid stage, fourth ulceration. However, two forms of this disease are recognized, one following the above clinical course and the other, which is quite rare, in which the dermatitis premycotic or eczematoid stage is omitted and the cutaneous tumor nodules appear rather suddenly. (To the patient.) Have you had any watery breaking out on your fingers, or any blisters which contained a clear fluid previous to the appearance of these nodules in your skin?"

Patient: "Yes, I did."

Dr. Harless: "When did you have these?"

Dr. Leger: "Did you not tell me this morning that you have had trouble with your skin for about eight months?"

Patient: "Yes, altogether about eight months."

Dr. Harless: "I think the histology is that of a mycosis fungoides. Of course, this is the tumor stage with ulceration which is present above the eye. Histologically, there are some plasma cells, mononuclear cells, but no giant cells which you find in tuberculosis or leprosy. We have not stained the slide for bacteria as yet, but we make a tentative diagnosis of mycosis fungoides. There is definite clumps of puss cells in the tissue, probably causing the infection in his arm which followed the biopsy."

Dr. H. R. Wahl: "I have nothing further to add

*The tumor clinic of the University of Kansas Hospital is held weekly, under the supervision of Dr. M. S. Harless, Instructor of Pathology and Surgery; and is regularly attended by the hospital staff and faculty. The above clinic was held on January 22, 1942.

except that on looking at the slide it looked like mycosis fungoides. It did not look like leprosy."

Dr. Harless: "Does anyone want to suggest treatment? It is my idea that this is a fatal condition."

Dr. Major: "That is right, it is fatal."

Dr. G. M. Tice: "X-ray therapy on these lesions may be of some benefit. They may be classed with the lymphoblastomas which are definitely radio sensitive. We had a patient here six or eight years ago with a mycosis fungoides lesion on the scalp which we treated with x-ray. The lesion went down but later reappeared and the patient died."

Question: "About how long would you say this patient has?"

Answer: "About one or two years, I believe."

This patient was returned to the Out-Patient Department with a diagnosis of mycosis fungoides; prognosis poor; x-ray therapy recommended.

ADENOFIBROMA OF AXILLARY BREAST

Case F. M., presented by Dr. Tom Johnson, Senior Surgical Resident.

Dr. Johnson: "This nineteen-year-old white female was admitted with the chief complaint of swelling under her left arm. She noticed this first in April, 1941. It enlarged gradually so that by October, it was one-half its present size. On admission, the growth measured about the size of a goose egg. The patient has gained four pounds since October. The mass bothers her only by getting in the way of her clothes and by being slightly tender."

The patient was dismissed and Dr. Johnson explained the gross specimen.

Dr. Johnson: "We took this out yesterday under local anesthesia. It was high up on the left side of the breast near the axilla but did not seem to be attached to any of the deep structures. No nodes were found at the time. The growth was well encapsulated and came out very easily. It was not apparently attached to the tail of the breast which frequently extends into the axilla."

Dr. Harless: "A section through the specimen shows grossly a fibrotic and glandular growth which is well encapsulated and pedunculated. Histologically, the picture is typical of an adenofibroma of the breast. I think that the unusual thing here is the large size attained and the pedunculated nature. It is also well to remember that a tongue of breast tissue frequently extends out toward the axilla and tumors both benign and malignant are occasionally found in it."

PONTINE TUMOR OF BRAIN

Third case, K. B., a brain tumor. Abstract of history by interne, Dr. Robert Turner.

This twenty-five-year-old white male was admitted three days ago complaining of paralysis of his left

side and progressive blindness. He was perfectly well until about two weeks prior to admission when he began to develop numbness in his left hand. The numbness spread rapidly and within the next four or five days involved the entire left side. About the same time the patient began having diminution of vision in both eyes. This progressive blindness was rapid and on admission the patient's vision was very poor. At the same time the patient noticed impairment of vision, he began to have weakness of the left side of his body which was progressive but had not progressed to complete paralysis. There has been no personality change, no headaches, no nausea or vomiting or evidence of hypertension.

Physical examination revealed an obese white male, not acutely ill. Pupils are equal but do not react to light. There was a lateral nystagmus and an absence of upward and downward gaze. There was slight congestion of both optic discs but not definite choking. There is some contraction of the nasal field of vision. There was slight ptosis of the right eyelid. B.P. 150/100. There was a positive Babinski on the left, with the remainder of the reflexes being physiological. There was motor weakness of the entire left side, about fifty per cent normal strength. There was diminished sensation to touch over the entire left side of the body with some paraesthesia or burning sensation.

The laboratory examination was essentially normal. Spinal puncture, January 20, showed initial pressure of 240 mm. of cerebrospinal fluid with negative Queckenstedt. The fluid was clear. The total protein was 250 mg.

Dr. Harless: "I wish to demonstrate this patient's eyes. (Moving his fingers before the patient's eyes) Please follow my hand. As you will notice, he has a paralysis of the outer and superior rectus muscles. The patient also complains of a burning sensation over his body. There is a positive Babinski on the left and ankle clonus on the left."

"This patient has been seen by Dr. D. F. Coburn, who suggests that there is a lesion pressing on the corpora quadrigemina."

Dr. Bowser: (presenting plates of the skull) The AP and PA plates of the skull show the findings to be normal. There is no evidence of increased intracranial pressure."

A tentative diagnosis of brain tumor was made; on January 29 ventriculograms showed moderate displacement of the third ventricle to the left and lack of visualization of the fourth ventricle. A diagnosis of brain tumor of the pontine angle was made. A tumor in this region was considered inoperable and x-ray treatments were given. The patient declined rapidly and died February 11, 1942. Autopsy

showed a large poorly circumscribed brain tumor in the pontine region with pressure on the corpora quadrigemina and the nuclei of the tegmentum mesencephali.

DESMOID OF EXTERNAL OBLIQUE

The fourth case, L. S., presented by Dr. Tom Johnson, Senior Surgical Resident.

Dr. Johnson: "This twenty-two-year-old white female complains of a growth in her abdomen. She first noticed a small lump in the left side of the abdominal wall which has gradually increased in size. When first seen it was the size of her little finger. Now it is about the size of a banana. It is tender to touch but there is no severe pain. She has lost twenty pounds in weight. She has had no cough or expectoration. She is married. Her menses have been entirely normal. There has been no change in her bowel habits. On examination we could find nothing in her neck in the form of glands. Neither is there any demonstrable site for a primary tumor. It is apparently in the abdominal wall, freely movable and slightly tender."

Question: "Did it come on following any lifting or straining?"

Patient: "No, not than I know of."

Question: "What is your tentative diagnosis?"

Dr. Johnson: "Benign tumor of abdominal wall."

Question: "Is there a burning sensation?"

Patient: "No."

Dr. Wahl: "I think the most hopeful thing about this case is that she does not look like she has a malignancy. I think an exploratory will reveal something easily taken care of."

Dr. Harless: "This growth is not located where we usually think of a desmoid. This growth is in the upper left quadrant and away from the rectus sheath. Also it does not act like an interstitial hernia. If it were a bit of omentum which had calcified, it would be very much more firm. I recently saw a case of hemorrhage into the rectus muscle but it was more painful than this is."

Dr. Wahl: "Could this be a desmoid? These do occur in the abdominal wall at the edge of the rectus sheath."

The growth was later removed under local anesthesia and histological section showed it to be a dense fibroma or desmoid of the abdominal wall.

CARCINOMA OF LIP

The next case, J. W. S., carcinoma of the lip, presented by Dr. John Bowser, Resident in Radiology.

Dr. Bowser: "This is a seventy-year-old white male who noticed a rough area on his lower lip in April of 1941. He thought it was due to a sharp tooth. It did not heal but increased in size. Three weeks prior to admission a knot was noted beneath

his left jawbone. The lesion on his lip has been biopsied and he has received a tumor dosage of superficial x-ray therapy. Of interest is this gland beneath the mandible about two cm. in size."

Dr. Tice: "This is an interesting case because there is a question as to whether the gland was movable or fixed and whether surgery should be attempted or it should be treated with x-ray therapy alone. Dr. Padgett thinks it may be removed."

Dr. Harless: "The pathological diagnosis of the lesion on the lip is a squamous cell carcinoma, Broders' Type I or II. I have seen Dr. Padgett on occasion remove glands which were considered fixed by taking a portion of the mandible away with the gland. Of course, this is not as easy to do."

This patient was sent to surgery where the gland was excised and found to be metastatic squamous carcinoma. It was not invading the mandible.

TUBERCULOSIS CONTROL

EXCLUDING TUBERCULOSIS FROM THE NAVY*

Compactness of living spaces aboard a naval vessel is a necessity. Advances in ship construction from the standpoint of ventilation and sanitation in general have been made, but men living aboard are still somewhat crowded. Under such conditions an open case of tuberculosis is a real menace. Medical officers are on the alert, but the average sailor likes to think of himself as a rugged, hardy individual and will not, as a rule, report to the sick bay unless he really feels sick.

No applicant showing any degree of adult type tuberculosis is acceptable. Men in the service who develop tuberculosis are retired and are not subject to recall to active duty, even with long standing arrest and minimal lesions.

The medical department of the Navy has recognized that at least thirty per cent to forty per cent of minimal cases will be missed by well-trained phthisiologists depending upon the conventional methods of physical examination alone. The criterion to be used in weeding out tuberculosis must be radiography. What form of radiography might be most practical for the Navy has been studied for some years. After carefully weighing the advantages and disadvantages of the several methods now avail-

* From Tuberculosis Abstracts, March, 1942. Reprinted from Pulmonary Tuberculosis, Its Exclusion from the Navy, Robert E. Duncan, M.D., Amer. Rev. of Tuberc., Dec., 1941.

able, fluorography with the thirty-five mm. film was found to be the best solution to the problem.

Speed is an important factor during a period of mobilization. A smooth working team can easily turn out from 100 to 150 films per hour. At present, examinations are not exceeding the rate of eighty per hour in the interest of careful posturing and some regard for the life of the x-ray tube.

However, these miniature films are not used for fine diagnostic work, but serve merely as a sieve to screen out the abnormal from the normal chest. In any case showing a lesion or even a questionable area, a standard fourteen by seventeen inch celluloid film is made for confirmation and accurate diagnosis. The method has definitely passed the experimental stage and it is ideal for mass thoracic survey work. At one training station photofluoroscopic examinations of 5,171 recruits were made. These men had already passed two stringent physical examinations. Yet, of these recruits, fifteen men showing soft infiltration in the lungs and three with multiple calcification and fibrosis of a disqualifying extent were transferred to the hospital for further study and disposition.

The incidence of tuberculosis in the Navy during normal times is not high and has been steadily declining.

TUBERCULOSIS IN THE ARMY*

The author's paper, presented May 8, 1941, was largely a criticism of certain faults in the program for detecting tuberculosis among inductees. By December, 1941, however, he was able to add to the summary the following:

"Since presenting this paper the Army Tuberculosis Survey has been improved. Practically all inductees are now being x-rayed prior to induction into the Army. Tuberculous inductees are not enrolled. It is considered that the Army now has an excellent program of tuberculosis survey."

The mobilization survey of 1941-45 will be the greatest case-finding effort ever carried out in this country. Its purpose will be to: (1) Detect chest diseases which would render the individual incapacitated for active military service; (2) detect diseases which may be so aggravated by military service that the individual becomes incapacitated for military service; (3) detect, especially, pulmonary tuberculosis with subsequent isolation from contact with young non-infected individuals; (4) report all tuber-

culous individuals to proper state health authorities.

The demobilization survey will consist of the routine general physical examination followed by an x-ray examination of the chest. Thus far, the x-ray examination has been made shortly after induction, and for this purpose the fourteen by seventeen inch film has been mostly used. At present and in the future the x-ray survey will be made chiefly by use of fluorograms, using the four by five inch films. Two films are made, one of which is sent to the War Department for permanent record. Upon demobilization, two additional fluorographic films will be made with like disposition of films.

The chief fault of this plan, namely, that the x-ray film of the chest is usually not made until after induction, has been corrected.

Another fault is that inductees may be discharged to their own care unless in need of hospitalization. Most medical officers will tend to err on the side of safety and many tuberculous inductees will be sent to Army hospitals who should have been discharged to their homes. When viewed from the standpoint of epidemiology, however, this may have the advantage of bringing a large number of cases under control and thus decreasing tuberculosis in the community.

Mobilization regulations allow the induction of an individual with reinfection tuberculosis when the process is minimal as to extent and arrested. This can be done when, in the opinion of the examiner, the lesion is not likely to become reactivated under the conditions of military service. This is a dangerous exception for many experts are able neither to estimate properly the true potentialities of a fibrous, tuberculous process nor the "conditions of military service."

Through this contemplated survey, thousands of new cases will be detected. It is important to plan for their care. No official estimate as to the number that will be discovered has yet been made but the author hazards the guess that between 1941 and 1945, a grand total of 88,000 cases will be detected.

About 2,350,000 babies were born in the United States in 1940, the highest number since 1930, according to a report by the Bureau of the Census. The total was nearly 100,000 greater than in 1939, and the increase lifted the national birth rate from 17.3 to 18.0 live births per thousand of population. From a rate of 24.2 in 1921 the rate continuously declined to its present point, 16.5, in 1933. Since then it has risen irregularly. The Census Bureau points out that the long-range tendency is still downward, the present rate resulting from the fact that babies born from the greatly increased volume of marriages following the first World War are now coming into reproductive ages.—The Diplomat.

*From Tuberculosis Abstracts, March, 1942. Reprinted from Tuberculosis in the Army, William C. Pollock, M.D., Amer. Review of Tuberc., Dec., 1941.

MAINTAIN PRESENT DEPLETION ALLOWANCE

The Treasury Department of the United States has again contended that the depletion Allowance is unreasonable and should be reduced or eliminated.

The oil and mining industry contends that this provision is a fair, equitable and reasonable allowance and has been allowed since 1913. It was in the interest of economy and simplification that the method of percentage depletion was adopted by Congress in 1926.

Congress and the public recognize that oil and other minerals in place represent capital and that this capital should be returned to taxpayers by Depletion Allowance incident to the extraction of these natural resources. Based on sound business policy, Depletion, as well as Depreciation, was formulated to return over its useful life, the capital invested to produce income.

Oil and other minerals cannot be replaced like manufactured products and agricultural commodities. The production and sale of such minerals represent the disposal of a part of the capital assets of the property owner.

The oil producer must continue exploratory development to maintain his business. Oil reserves are discovered as a result of successive dry holes, and their costs, including intangible expenses for leases and geological services, are rightly chargeable to producing properties.

By elimination of the Depletion provision, many small operators will be bankrupted and forced to retire from business. It is the small operator, to a large extent, who discovers new reserves, which are so vital to the successful prosecution of our war effort.

Statistics reveal that 25 to 30 per cent of the wells drilled result in dry holes. For this reason, the 27½ per cent Depletion provision limited to 50 per cent of net income in the Revenue Act appears equitable and fair.

It is, therefore, resolved by the Kansas Industrial Development Commission that the present Depletion Allowance of 27½ per cent is fair and reasonable and should be maintained and unmodified so that exploratory development of reserves may continue uninterruptedly to aid in winning the war.

THE KANSAS INDUSTRIAL DEVELOPMENT COMMISSION

TOPEKA

KANSAS

NEWS NOTES

PROCUREMENT AND ASSIGNMENT

The February 21 issue of the Journal of The American Medical Association contains a very complete and interesting description of the present program for the procurement and assignment of doctors of medicine, dentistry and veterinary medicine. Since the program is a very important one and since it presents an opportunity for every physician to provide valuable service to his country, it is urged that every member read the above summary carefully and familiarize himself with all aspects of the plans being made on this subject.

The Army, the Navy, the National Selective Service Headquarters, the United States Public Health Service, the Civilian Service Commission and all other agencies who will need the services of physicians during the present emergency have entered into an agreement wherein the Procurement and Assignment Service in Washington will provide all necessary medical personnel. In order to protect civilian necessity, the Procurement and Assignment Service has adopted a policy, which will be followed as completely and as long as possible, wherein the services of physicians will not be called for or accepted unless their availability from the standpoint of civilian needs has been certified by state committees of procurement and assignment composed of individuals who are familiar with local requirements. A questionnaire is to be issued within the near future wherein every physician in the United States will be extended an opportunity to volunteer his services for the place or places in which he believes he can best assist. The questionnaire replies will be filed by the Procurement and Assignment Service at Washington, in accordance with age groups, specialties, types of training, etc., and will be utilized as a means of filling medical needs on the above basis.

Since a considerable number of physicians have already volunteered their services to the Procurement and Assignment Service, a considerable number of names are now being received by the state procurement and assignment committees for consideration and certification. The Kansas Committee on Procurement and Assignment has to date received seventy-five names for this purpose.

The Kansas Committee on Procurement and Assignment, as was announced in the last issue of the Journal, is composed of the following officers and past-presidents of the Society: Dr. F. L. Loveland of Topeka, Chairman; Dr. C. D. Blake of Hays; Dr. H. N. Tihen of Wichita; Dr. W. M. Mills of Topeka; Dr. C. F. Huffman of Columbus; Dr. N. E. Melencamp of Dodge City; Dr. Marion Trueheart of Sterling; and Dr. C. C. Nesselrode of Kansas City.

INDIGENT MEDICAL CARE

The central office received the following communications on March 17 from Mr. Fay N. Seaton, chairman of the Kansas State Board of Social Welfare. As will be noted, the communications contain some information of importance in regard to indigent medical care.

"As you know, the State Board of Social Welfare has been very much interested in the adoption by the County Boards of Social Welfare in Kansas of plans for the medical care of the indigent which are of such standard as will meet with the approval of the Federal Social Security Board,

and secure federal participation of fifty per cent in the expenditures thereunder for the recipients of old age assistance, of aid to the blind, and of aid to dependent children.

Some thirteen counties in Kansas are now operating under such plans and a number more are considering doing so. In one county of the State, as you know, by the adoption of such a plan the taxpayers of Kansas were saved approximately \$33,500 a year. In another, with the County Board of which members of the State Board recently discussed such a plan, the possible saving to the taxpayers was figured at around \$32,000. In a third county, which will soon adopt the plan, it looks like the saving will be about \$28,000 a year.

Such plans are made possible by the cooperation of the county medical societies and by the willingness of the local physicians to do this work for the needy at a rate considerably under the regular fee schedules; and, without such cooperation on the part of the physicians, it would have been impossible for the progress to have been made in this direction.

I am informed by the Federal Board's consultant on medical care to the indigent that Kansas is leading the procession of states in this regard; and, as a matter of fact, Kansas is really out in front of the Federal office itself, as we developed our own plans, which have worked out quite successfully. They have met the general approval of the recipients of the medical care as well as that of the taxpayers and of the members of the medical societies.

For the information of the county authorities, the State Board of Social Welfare recently sent to them the attached Chairman's Letter No. 292, dealing with the medical care; portions of which I have thought might be of interest to your readers.

Sincerely yours,

Fay N. Seaton, Chairman."

"To: County Directors of Social Welfare

Re: MEDICAL CARE

The Welfare Act of Kansas provides that assistance shall be 'compatible with decency and health.' The term 'health' is used in a positive manner. It implies not only treatment when acute illness occurs but services for the prevention of disease: facilities for rehabilitation; as well as constructive planning for all health needs. An adequate medical care program is a vital part of any public assistance program. Medical care must be planned in relation to and closely integrated with an assistance program which provides for adequate food, shelter, fuel, clothing, and other essentials of life. Unless there is an adequate assistance program, the best possible medical program for recipients loses a great deal of its effectiveness. The two programs must go hand in hand as their success depends upon each other.

The State Department has been concerned about the problem of medical care for recipients of public assistance. We are not alone in our concern since this problem is one which has demanded the attention of county boards, welfare directors, physicians, dentists, hospitals, and public minded citizens. To achieve the goal of providing adequate medical care for those who cannot meet its costs from their own resources requires the effort and cooperation of all of us. In addition, we need the combined resources of local, state, and federal funds.

For some time we have been discussing with representatives of the Social Security Board plans for medical care in which we might receive federal participation. In a recent communication from the regional office of the Social Security Board, we have received permission to develop our

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medical insurance plan which is now in operation in thirteen counties of the State. The Social Security Board will match payments under the medical insurance plan up to the federal maxima, providing that certain conditions are met.

These conditions are:

- A. That effective immediately, each county will submit to the Bureau of Public Assistance for review the medical plan under which it is operating. If there is a formal contract, a copy of the contract must be admitted. If you are operating under a fee schedule plan, a copy of the fee schedule is necessary. If you have no formal contract, a detailed write-up of your present plan and the basis of operating must be submitted. Any changes in medical plans shall be submitted accordingly.
- B. All plans on which federal participation is contemplated will be reviewed by the State Department and submitted to the Social Security Board for approval before they become operative. Prior approval must be secured on all plans in which the Social Security Board participates before the plan becomes effective. Since considerable time will be required for clearance, it is necessary for counties whose present contracts will soon expire or who are negotiating on new contracts providing for federal participation, to take into account the time element necessary so that there will be proper clearance and prior approval secured before the plan is put into operation by the county department.

If the plan submitted by the county department provides for federal participation, it will be reviewed in the light of the following criteria by the Bureau of Public Assistance of the State Department before it is sent to the Social Security Board for comments:

1. That provision is made for the best professional services available within the local area to the participants and that professional standards and quality of service will be maintained by the individuals offering such service.
2. That necessary medical services provided through other facilities in the State or the community are not duplicated in the plan.
3. That the participants have free choice of physician, limited, of course, to the professional group included in the plan or the individual members of the professional group who are willing to offer their services under the plan.
4. That provision is made for voluntary participation in the plan by the recipient.
5. That provision is made for assuring that recipients who do not desire to participate in the plan will receive necessary medical care in the event it is needed.
6. That any amount providing for medical care and included in the categorical recipient's award is not restricted to that use.
7. That no automatic reductions of assistance grants will be imposed if the recipient fails to pay his medical fees. Any reductions made will follow the recognized procedures by reviewing the recipient's situation in respect to his total requirements and resources.
8. That provision is made for the inter-change of information between the participating physicians and the county department.
9. That the fee for the services provided for in the contract is reasonable and within the agency's ability to pay.
10. That eligibility for medical services is determined by the county department of social welfare and on the same basis as eligibility for other types of assistance.

Certain criteria enunciated above, of course, will not appear in the formal contract. It is, therefore, necessary

that any counties submitting such contracts supplement the contract with details as to the methods that will be used in conforming to the recommended criteria. We will be especially interested in the quality of service, the inclusiveness of the service, who gives the service, the protection of the client's rights in the contract, and whether the plan in any sense is restrictive either in scope or in the method of making payments.

The State Department hopes that it will be possible at a later date, after a review of various plans, to develop some fundamental standards or principles that may be used by the county in arriving at an acceptable plan for your particular community. We fully recognize that to carry out our supervisory responsibility we must, after review of all materials submitted, establish some standards or a frame work within which the State and counties may operate to the end that the functions of administering the public assistance program may be effectively discharged in all counties of the State. However, the development of a medical plan for the care of assistance recipients must be left for the most part to the local county department since the plan developed depends upon local conditions, personnel, and available facilities. We do believe though that any plan should make the maximum use of local facilities and be broad enough in its scope to include all necessary service at the lowest possible cost to the public.

It is hoped that this letter will be of help to you in developing medical plans. If possible, we would suggest a plan providing for federal participation if local conditions are conducive to such a plan, since we need to utilize federal funds whenever possible so as to conserve local and state funds."

Fay N. Seaton, Chairman.

RESIGNATION

Dr. John M. Porter of Concordia, recently forwarded his resignation as Secretary of the Society to Dr. C. D. Blake, President.

Dr. Porter's resignation occurred by reason that he holds a commission as Lieutenant Commander in the Navy and as he was called to active duty on March 6.

His successor has not as yet been designated.

KANSAS CONFERENCE

The Kansas Conference of Social Work will hold a training institute in Wichita on April 6 and 7. Health will be the feature of this year's conference. Mrs. Lucile Smith, Medical Consultant to the Social Security Board at Washington, D. C., will discuss "Planning the Medical Care Program" at the banquet to be held on Tuesday, April 7.

An invitation is extended to all members of the Society to attend any of the meetings desired.

MEDICAL CIVILIAN DEFENSE

A large number of county medical societies of the state are engaged in completing plans for civilian medical defense.

All county societies and all official representatives have received a Society bulletin wherein was outlined recommendations made by the National Office of Civilian Defense for programs of this kind.

The salient features of the program may be summarized

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* *J.A.M.A.*, 93:1110, Oct. 12, 1929

Bruckner, Die Biochemie des Tabaks, 1936

** *The Military Surgeon, Vol. 89, No. 1, p. 7, July, 1941*

CAMEL

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in four questions: that if a local disaster should occur where would the patients be treated; would adequate medical assistance be readily available; would each person rendering medical assistance know where he is to go and what he is to do; and would a sufficient amount of necessary supplies be available?

Even though smaller counties may find it difficult or impossible to organize the complete program recommended by the Office of Civilian Defense, it is believed that every county can prepare a satisfactory and efficient arrangement in respect to the above questions. It is also believed that all counties should do so without delay. The probabilities of sabotage, bombing attacks and other disasters, could readily provide a sizeable need for emergency medical assistance at any place in the state, at any time.

The recommended procedure for institution of a civilian medical defense program is as follows: that if a local director of civilian medical defense has not as yet been appointed, the county medical society or the physicians in the community designate a physician to be appointed for that purpose and recommend his official appointment by the local chairman of civilian defense and that the physician appointed for this purpose then arrange to hold meetings attended by doctors of medicine, doctors of dental surgery, pharmacists, nurses, hospital representatives, ambulance owners, garage owners and other needed individuals where-in plans can be made for the care and transportation of injured persons, for the acquisition and location of necessary supplies, and for arrangements to have medical personnel and other assistance available and stationed on brief notice.

EXECUTIVE SECRETARIES

Two county societies have announced the employment of new executive secretaries during the past month.

The Crawford County Medical Society has employed Mr. D. D. Jeffers to serve as its full time secretary and the Sedgwick County Medical Society has employed Mr. Oliver Ebel to fill the place of Mr. John F. Austin, who is now serving in the Army.

Mr. Jeffers has assisted the Crawford County Medical Society during the past two years in the operation of its indigent medical care plan. Mr. Ebel formerly served as chief probation officer for the Sedgwick County Juvenile Court.

COUNCIL MEETING

A joint meeting of the Council, the Society Committee on Medical Economics, and the Kansas State Board of Medical Registration and Examination was held in Topeka on February 22.

Members who attended were as follows: Dr. C. D. Blake of Hays, Dr. John L. Grove of Newton, Dr. Marion Trueheart of Sterling, Dr. F. L. Loveland of Topeka, Dr. W. P. Callahan of Wichita, Dr. Geo. O. Speirs of Spearville, Dr. J. W. Randell of Marysville, Dr. J. H. A. Peck of St. Francis, Dr. L. S. Nelson of Salina, Dr. Herbert Atkins of Pratt, Dr. F. R. Croson of Clay Center, Dr. J. L. Lattimore of Topeka, Dr. John M. Porter of Concordia, Dr. O. W. Davidson of Kansas City, Dr. Philip W. Morgan of Emporia, Dr. C. E. Joss of Topeka, Dr. C. C. Nesselrode of Kansas City, Dr. J. F. Gsell of Wichita, Dr. J. E. Henshall of Osborne, Dr. J. F. Hassig of Kansas City, Dr. H. E. Haskins of Kingman, Dr. O. L. Cox of Iola, Dr. C. S. Huffman of Columbus, Dr. Ralph G. Ball of Manhattan,

Dr. Walter Stephenson of Norton, Dr. F. E. Richmond of Stockton, Dr. C. M. Miller of Oakley, Dr. Barrett A. Nelson of Manhattan, Dr. F. E. Wrightman of Sabetha, and Mr. Clarence Munns was present as Executive Secretary.

The major items of discussion at the meeting pertained to procurement and assignment of physicians, civilian medical defense, the illegal practice of medicine and surgery by unauthorized persons, and a considerable number of matters of medical economic interest.

APPOINTMENT

Dr. C. D. Blake, President, and Dr. H. N. Tihen, Vice-President, have announced the appointment of Dr. C. H. Lerrigo of Topeka, to serve as chairman of the Society Committee on Control of Tuberculosis, during the remainder portion of this year and during 1942-43.

Dr. Lerrigo succeeds Dr. Omer M. Raines of Topeka in this position. Dr. Raines was recently called to active duty in the Medical Corps of the Army and thus resigned his place as chairman of the committee.

LOCATIONS

The Society central office knows of several locations wherein the service of physicians are desired.

Likewise, several of the state hospitals have vacancies on their staff which they particularly desire to fill.

Any members interested in opportunities of this kind are invited to correspond with the central office.

BOARD OF HEALTH SUPPLIES

Dr. F. C. Beelman, secretary of the Kansas State Board of Health, issued the following bulletin on March 2:

"The serious difficulty we are having in obtaining supplies, due to the national emergency, has prompted us to ask for your cooperation. We would appreciate it very much if you would go over your outfits for mailing specimens to the Division of Public Health Laboratories, and return to us, at our expense, all outfits which are not usable. You may have outfits that contain no tubes, the medium has dried out, or in which the preserving solution has evaporated. You may have typhoid vaccine bottles (those furnished by the State Board of Health) either empty or out-dated, which we would like to have returned.

It should be clearly understood that we are not curtailing our service to you. We are just asking your cooperation in the collection of old mailing containers, bottles, etc."

OBSTETRICAL AND GYNECOLOGICAL MEETING

The Society Committee on Maternal Welfare forwarded the following bulletin to the county medical societies and official representatives on March 16:

"A very important post graduate meeting on Obstetrics and Gynecology is to be held at St. Louis, Missouri, on April 6-10. The meeting is the Second American Congress on Obstetrics and Gynecology which is sponsored by the American Committee on Maternal Welfare.

At this meeting the problem of human reproduction will be studied from every angle with ideas and discussions from the standpoint not only of the medical profession,

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but the nursing profession, public health officials and administrative officials. Each of the groups will be represented at the meeting and on the program. It is the hope that out of this common meeting of minds that some of the answers to our ultimate problems may be arrived at.

Our committee feels that the meeting will be of particular interest and assistance to Kansas physicians as there has been arranged three separate approaches to the medical program. First, the formal presentation of papers. Second, demonstrations by specialists of the common obstetrical and gynecological procedures. Third, a new departure in medical meetings, in the private consultation service which is being offered each day with twelve nationally known specialists who by appointment will discuss privately with any doctor any problem which he might have.

Since this year's meeting is closely situated to this state it is hoped that a sizeable Kansas attendance may be possible. Detailed information concerning the program and events of the meeting may be obtained from the American Congress on Obstetrics and Gynecology, 650 Rush Street, Chicago, Illinois. If you would be good enough to make an announcement concerning the meeting at the next meeting of your society, our committee would greatly appreciate your doing so.

Ray A. West, M.D., Chairman,
Committee on Maternal Welfare."

MINUTES

The following are the minutes of the meeting of the Committee on Legal Medicine which was held in Wichita on February 15:

"A meeting of the joint committees of doctors and lawyers known as the Committee on Improvement of Medico-Legal Relationship was called for February 15, 1942, at one o'clock p.m., in the Allis Hotel at Wichita. The following were present:

Co-chairman Dr. Earl L. Mills and Claude I. Depew, of Wichita, Dr. J. L. Lattimore of Topeka, and John H. Hunt of Topeka, Roy C. Davis of Hutchinson, Thomas M. Van Cleave of Kansas City, Mr. Bernard L. Sheridan of Paola, President of the Bar Association of the State of Kansas, was also present; and for a part of the meeting Dr. Charles Rombold of Wichita, Chairman of the Industrial Committee of the Sedgwick County Medical Society was also present.

It was explained that the purpose of the meeting was to get acquainted, and to receive and discuss suggestions as to activities which might be of interest and benefit.

There was some discussion of the activities of other committees of the Medical Society which might overlap the activities of this committee. It was the consensus of opinion among those present that the efforts and activities of this committee would be confined to matters of mutual interest and professional benefit to doctors and lawyers, where the two professions came in contact with each other.

It was suggested that one of the primary matters to be considered by the committee should be that the relationship between doctors testifying as medical experts and lawyers conducting the cases in which they testify. Mr. Hunt explained somewhat in detail the "Minnesota Plan", under which the Minnesota State Medical Association has established a standing committee of doctors to review the records of any expert medical testimony where the judge before whom it is given has reason to believe that the doctor witness was not giving honest and sincere testimony.

A proposed bill suggested by Judge C. A. Walsh of

Washington, Kansas, and submitted to the committee by Clarence G. Munns, Executive Secretary of the Kansas Medical Society, was read. It deals not only with expert medical evidence but also evidence of other experts, and would provide for the appointment of one or more experts by the court, who would hear and examine the facts and make a report to the court. After opportunity for counsel to make exceptions to the report and arguments thereon, the facts determined in the report would be approved by the court and would thereafter be considered as facts established and adjudicated in the case. Some of the lawyers present suggested that such an act might be attacked on the ground of unconstitutionality because it might deprive litigants of the right to trial by jury on certain issues of fact. The matter was left open for further consideration at the next meeting.

A letter was read which had been written by the Journal of American Insurance to the Secretary of the Kansas Medical Society suggesting that the Medical Society might wish to publish in its Journal an article by Dr. E. M. Hammes concerning the "Minnesota Plan" for handling medical testimony.

Dr. Mills presented for discussion the matter of asking lawyers to cooperate in seeing that doctors are paid for medical services which are included in insurance indemnity payments. It seemed to be the consensus of opinion that there was not likely to be any difficulty about doctors getting their money where the settlements of claims were handled by lawyers. As to the matter of insurance companies settling directly with claimants without consulting the doctors or arranging for their payment, that was thought to be a matter over which the lawyers did not have any control, but one which concerned the doctors and the insurance companies. The possibility of the Medical Society proposing a bill in the legislature was discussed. It was also suggested that if the committee and the Associations recommended an endorsement of the idea, an article might be written for the Journals touching upon the matter of lawyers cooperating with doctors in the matter of payment of medical fees where settlements are handled by lawyers.

The next matter discussed was the coroner law. The doctors present complained bitterly of the present situation with respect to coroners, and suggested the possibility of a law which would create a state medical examiner or some such officer who would then select doctors in the various counties or districts to perform the duties now performed by coroners. However, that was another matter which it was thought was primarily a problem of the Medical Society and of the doctors.

Concerning the improvement of relationships between the doctors and lawyers, there were several suggestions; one was for joint meetings which would be primarily social gatherings, but which also might include program features or papers or speeches relative to matters in which both groups would be interested. Another was a suggestion that doctors might appear at the legal institutes and talk for a few minutes on matters of mutual interest. Another was that the programs at Bar conventions and medical conventions might include speeches or a paper by members of the other group. Another was that the Journal of The Medical Society might contain occasional articles by lawyers, and the Journal of the Bar Association might contain occasional articles by doctors. It was also suggested that either group might display an exhibit of some sort at the convention of the other group.

There was a short discussion of the subject of malpractice and suits arising from malpractice claims. It was suggested by Mr. Hunt that the doctors might establish a grievance

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committee in communities where they have local societies, and that complaints against members of their profession be considered by such committee. Also that lawyers consulted regarding prospective malpractice claims might submit the facts to such a committee before determining whether or not to bring suit. Mr. Davis made the suggestion that there might be a conflict with the Medical Protective in carrying out such a suggestion.

Dr. Lattimore stated that at some time in the future it might be practicable and desirable to conduct joint clinics for the benefit of the lawyers and doctors particularly interested in matters concerning both groups, at which a day might be spent in the study and discussion of mutual problems.

It was decided to report the suggestions made at this meeting to all the members of the committee, including those who did not attend; and that another meeting should be held in April at which a special effort would be made to get as large an attendance as possible, and at which the committee would decide on recommendations to submit to their respective state conventions in May.

The meeting adjourned to meet again at the call of the co-chairmen."

COUNTY SOCIETIES


The Cowley County Medical Society met in Arkansas City on February 19. The society discussed local plans for civilian medical defense at the meeting. Members of the Winfield Red Cross also presented a first aid demonstration.

The Cloud County Medical Society met in Concordia on March 10. The following new officers were elected: Dr. Ross Weaver of Concordia as President; Dr. G. E. Martin of Concordia as Vice-President; Dr. C. D. Kosar of Concordia as Secretary-Treasurer. A successful diphtheria immunization program was reported and the county committee on medical defense was appointed. Those appointed as members of the committee for Cloud County are as follows: Dr. C. D. Kosar, Dr. G. E. Martin and Dr. Frank Kinnamon of Concordia.

The Crawford County Medical Society completed plans for the establishment of a local civilian medical defense unit at a meeting of that society held in Pittsburg on January 29.

The Lyon County Medical Society met in Emporia on March 3 at the Newman Memorial Hospital. Dr. E. H. Hashinger of Kansas City, Missouri, spoke on "The Many Manifestations of Hypothyroidism" and Dr. F. A. Carmichael of Kansas City, Missouri, discussed "The Use of Vitallium in the Closure of Defects of the Skull".

At a meeting of the Marshall County Medical Society held in Marysville on January 23, the following new officers were elected: Dr. B. W. Lafene of Marysville as President; Dr. J. W. Randell of Marysville as Vice-President; and Dr. O. G. Hutchinson of Marysville as Secretary-Treasurer. Dr. Clarence Elliott of Lincoln, Nebraska, was



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OTOLARYNGOLOGY—Two Weeks Intensive Course will be offered starting April 6th. Clinical and Special Courses starting every week.

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a guest speaker at the meeting and spoke on "Water Balance of the Body".

The Mitchell County Medical Society held a meeting in Beloit on February 11. Dr. A. E. Hiebert of Wichita spoke on "Burns" and Dr. W. A. Warren of Wichita spoke on "Hyperthyroidism".

The Pratt County Medical Society held a dinner meeting on February 27 in Pratt. Dr. C. T. Hinshaw of Wichita spoke on "Babies Are Human Beings" and Dr. James S. Hubbard of Wichita discussed "Diagnosis and Care of Intestinal Obstructions".

A meeting of the Saline County Medical Society was held in Salina on February 12. Dr. J. B. Fisher of Wichita spoke on "General Aspects of Nutrition" and Dr. Vincent Scott of Wichita spoke on "Vomiting in Infancy".

Dr. Andrew C. Ivy, of the Northwestern University School of Medicine of Chicago, was the guest speaker at a meeting of the Sedgwick County Medical Society held in Wichita on March 27. Dr. Ivy spoke on "Therapy of Hepatic Disease".

At a meeting of the Wyandotte County Medical Society held in Kansas City on March 17, Dr. J. Warren Manley of Kansas City, Missouri, spoke on "Diagnosing Tuberculosis" and Dr. A. H. Hinshaw of Kansas City spoke on "Hospitalization".

MEMBERS

Dr. Donald E. Bux, formerly of Manhattan, has been appointed as full time health director of Cherokee County, with offices in Columbus. Dr. Bux succeeds Dr. J. W. Speering who recently resigned to accept the position of medical director of the the Kansas Ordnance Plant at Parsons.

Miss Jane Griggs, who has been employed in the Society central office for the past few years, resigned her position on March 1 and was married to Lt. Ray Senate of the United States Coast Artillery on March 7.

Dr. C. A. Hellwig of Wichita, presented a paper on "Surgical Pathology of Goiter" before the Cook County Graduate School of Medicine in Chicago on January 29.

Dr. O. M. Heiberg, formerly of Manhattan, is now located in Worthington, Minnesota.

Dr. Gladys Huscher, who until recently was engaged in medical work in connection with a missionary school in Africa, is the author of an article entitled "Bringing the Healing Touch to Africa" which was published in the February 28 issue of the Evangelical Crusader. Dr. Huscher returned to her former home in Concordia after a hazardous Atlantic crossing made in December, 1941, and now expects to remain in Kansas during the duration of the war, by reason of her inability to obtain transportation to her post in Africa. Her article in the above publication is a very interesting description of the practice of medicine under primitive circumstances in the Congo.

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Dr. Paul H. Lorhan of Kansas City is the author of an article entitled "Convulsions During General Anesthesia, Report of a Case" which was published in the February issue of Archives of Surgery.

Dr. C. T. Moran of Arkansas City spoke on "Cancers and Tumors of the Eye" at a meeting of the Kansas City Society of Otolaryngology and Ophthalmology held in Kansas City recently.

DEATH NOTICE

Dr. Joseph E. Hawley, 89 years of age, died on February 11, at Burr Oak. Dr. Hawley was graduated from the St. Joseph Hospital Medical College of St. Joseph, Missouri, in 1882. He was an honorary member of the Jewell County Medical Society.

A.M.A. MEETING

"The American Medical Association is scheduled to hold its annual session for 1942 in Atlantic City in the week June 8-12," *The Journal* of the Association says in its March 7 issue. "Plans have been going forward steadily for this important meeting. Long before the United States entered the war, the House of Delegates and the Board of Trustees had agreed to endeavor to make this session an inter-American meeting, as an indication of the close relationship in medicine prevailing among all the American nations. The Council on Scientific Assembly and the secretaries of the various sections have been enlisting the attendance of physicians from the other American nations, including also contributions to the program and to the Scientific Exhibit.

"Already there are indications that many of the South American nations are inclined to participate. The Brazilian government has offered some exhibits dealing particularly

with yellow fever and malaria. Subject of course to the difficulties of transportation, there is definite promise of the attendance of some of the leading figures in medicine in South America, Canada, the West Indies, Mexico and Central America. As a part of the promotion of inter-American relations, some of the leading foundations in the United States have brought to this country young physicians who are now serving internships in American hospitals or who are undertaking graduate education or research in American medical schools and universities. No doubt many of these South American representatives will attend the annual session. Moreover, the Coordinator of Inter-American Affairs has also agreed to aid in the promotion of this project. The Department of State is arranging to extend an invitation on behalf of the American Medical Association to the official medical societies of all the South American countries. Every effort is thus being made to insure a successful conclusion to the project under the extremely difficult conditions which now prevail.

"The medical profession of Atlantic City and of New Jersey are doing their utmost to insure a successful meeting; several events of special interest in relation to the war are being scheduled. Official representatives of various governmental agencies concerned with the medical participation in the war have promised to be present and to contribute to the program.

"A few physicians have written to the American Medical Association suggesting the abandonment of the annual session for fear that enemy naval vessels or aircraft might select Atlantic City as the special object of their ministrations during the time of the annual session. The vast majority of the medical profession of the United States and the representatives of various governmental agencies who have been consulted have felt that the meeting should by all means be held as originally planned."

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ATTEND

the

83rd Annual Session of the Kansas Medical Society

GUEST SPEAKERS

Frank H. Lahey, M.D.
Boston, Mass.

Charles W. Mayo, M.D.
Rochester, Minn.

Joe V. Meigs, M.D.
Boston, Mass.

Alan Brown, M.D.
Toronto, Canada

H. R. Hildreth, M.D.
St. Louis, Mo.

Paul O'Leary, M.D.
Rochester, Minn.

W. D. Stroud, M.D.
St. Louis, Mo.

John M. Shea, M.D.
Memphis, Tenn.

Cyril M. MacBryde, M.D.
St. Louis, Mo.

Date: MAY 11, 12, 13 & 14

Place: FORUM, WICHITA

The Complete Program Will be Published in the April Issue of the Journal

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* *Laryngoscope*, Feb. 1935, Vol. XLV, No. 2, 149-154—*Laryngoscope*, Jan. 1937, Vol. XLVII, No. 1, 58-60 *Proc. Soc. Exp. Biol. and Med.*, 1934, 32, 241—*N. Y. State Journ. Med.*, Vol. 35, 6-1-35, No. 11, 590-592

BOOKS RECEIVED

COMMUNICABLE DISEASE NURSING—Theresa I. Lynch, R.N., Ed.D., Instructor in Education, New York University, Formerly Superintendent of Nurses and Director of Instruction, the Willard Parker Hospital, New York. Published by the C. V. Mosby Company, St. Louis, Missouri. The volume contains 678 pages, 156 illustrations and five color plates. Priced at \$3.75.

METHODS OF TREATMENT IN POSTENCEPHALITIC PARKINSONISM—Henry D. von Witsleben, M.D., Elgin State Hospital, Elgin, Illinois, and preface by Theodore J. C. von Storch, Associate Professor of Neurology, Albany Medical College, Attending Neurologist, Albany Hospital, Albany, New York. Published by Grune and Stratton, New York. The book contains 164 pages and is priced at \$2.75.

THE PRINCIPLES OF NEUROLOGICAL SURGERY—Loyal Davis, M.D., M.S., Ph.D., D.Sc., Professor of Surgery and Chairman of the Division of Surgery, Northwestern University Medical School, Chicago, Illinois. Second Edition published by Lea and Febiger, Philadelphia, Pennsylvania. Priced at \$7.00. The book contains 154 engravings, 298 illustrations, five color plates and 503 pages.

KANSAS MEDICAL ASSISTANTS

The Cowley County Medical Assistants Society held a meeting in Arkansas City on February 19.

The Sedgwick County Medical Assistants Society held a meeting in Wichita on February 19. Dr. J. W. Humphrey of Wichita showed movies of China. Dr. Humphrey re-

turned to the United States from China in 1940, where he was a medical missionary. A meeting of the organization was also held on March 18 to discuss plans for the state meeting in May.

The Shawnee County Medical Assistants Society held a meeting in Topeka on March 2. Mr. E. P. Heilpern, a former resident of Europe, now living in Topeka, spoke on "Flight from Austria".

Dr. Clyde D. Blake, President of The Kansas Medical Society, recently announced the appointment of the following as members of the Advisory Board to the Kansas Medical Assistants Society: Dr. J. L. Lattimore of Topeka; Dr. Philip W. Morgan of Emporia; Dr. L. B. Spake of Kansas City; Dr. Charles R. Rombold of Wichita; and Dr. H. E. Marshall of Wichita.

Annual dues of members of the Kansas Medical Assistants Society of fifty cents, are now past due. If you have not paid your dues send them to Mildred McClure, Recording Secretary 430 Brotherhood Building, Kansas City, Kansas.

It is necessary that your dues are paid to attend the state meeting of the organization in Wichita in May. Admittance will be by membership card. It is not, however, necessary that you belong to a local organization to become a member of the state group. A letter from your physician stating that you have been employed as an assistant for one year or longer and mailed with a remittance of fifty cents, is all that is required.

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Business Manager

AUXILIARY

PRESIDENT'S MESSAGE

When this issue of the Journal reaches you we should have all our arrangements completed for the annual convention at Wichita. We are urging and hoping that each auxiliary has a large delegation in attendance.

Purpose of the annual session:

- (1) To review and appraise the work of the year of the State board and of the local units;
- (2) To decide what work is to be undertaken for the incoming year;
- (3) To devise plans for carrying on that work.

The national president-elect, Mrs. Frank Haggard, of San Antonio, Texas, will be with us for part of the sessions. She will doubtless give us a partial outline of the work for the new year. This will be of special interest to all incoming presidents. You will receive a newsletter in April and this will bring to you the full program. Begin now to plan your attendance at all meetings of the convention and be ready not only to receive but to give constructive suggestions. Remember that:

Coming together is beginning,

Planning together is progress,

But working together is success.

We must zealously guard our organization during these trying months, probably years. It is vitally necessary that we maintain our local, state and national unity. We want to do our share in preserving medical democracy.

We are beginning now to have a new conception of duties and many new responsibilities. Before assuming any new tasks we must have the approval of the Advisory Board; in this way only can we be an asset and not a liability to The Kansas Medical Society.

Let us continue to develop a clear vision, born of high ideals and of determination to steadily move forward and grow in strength and effectiveness.

Sincerely,

Mrs. W. Y. Herrick.

STATE AUXILIARY GUEST

Word has been received by Mrs. W. Y. Herrick, President, that Mrs. Frank Haggard, President-Elect of the National Auxiliary, will be a guest at the annual session of the Auxiliary to be held in Wichita on Monday and Tuesday, May 11 and 12. It is hoped that as many of the members as can will be present on Monday for Friendship Day, to meet Mrs. Haggard.

Notice—All resolutions must be sent to Mrs. E. E. Tipin, 12 Linwood Blvd., Wichita, not later than May 11, in order to be considered at the annual session. Resolutions must be in writing and preferably should be typewritten.

ANNUAL MEETING

The Annual Meeting of the Woman's Auxiliary to the American Medical Association will be held in Atlantic City, New Jersey, on June 8-12, 1942. Haddon Hall will be the headquarters for the Auxiliary and all requests for reservations should be sent as soon as possible to Haddon Hall. Mrs. David Allman, 104 Charles Place in Atlantic City, is the Chairman of Woman's Activities. For rates for rooms please consult your current issue of the Bulletin.

AUXILIARY NOTES

The Women's Auxiliary to the Ford County Medical Society was entertained at a dinner meeting held at the home of Mrs. R. G. Kline in Dodge City in February. The following new officers were elected at the meeting: Mrs. C. M. Alderson of Dodge City as President; Mrs. Robert Daugherty of Mead as Vice-President; Mrs. A. B. Busch of Dodge City as Secretary; and Mrs. Donald Davis of Dodge City as Treasurer. Mrs. W. Y. Herrick of Wakeeney, State President of the Auxiliary, was the guest speaker at the March meeting of the organization.

The Women's Auxiliary to the Saline County Medical Society held a luncheon meeting in Salina during February. Hostesses were: Mrs. Harold Neptune, Mrs. George Stafford, Mrs. Leo J. Schafer and Mrs. Earnest Harvey, all of Salina. Mrs. W. Y. Herrick of Wakeeney, and Mrs. C. D. Blake of Hays were guests at the meeting. Mrs. Herrick spoke on "Purposes of the Auxiliary and Its Place in the Present War Crisis".

At the regular luncheon meeting of the Sedgwick County Auxiliary held during March, Mrs. E. S. Edgerton was the program chairman, Mrs. A. F. Wittmann, the social chairman and Mrs. W. J. Biermann, the chairman of decorations. The organization extends a welcome and special invitation to all members of doctor's families to attend the state meeting to be held in Wichita on May 11-15. The Auxiliary is assisting in all ways possible to make the meeting a successful event.

EXCERPTS FROM THE NATIONAL PRESIDENT'S LETTER

The Woman's Auxiliary can play a major role in the national defense program. Health and wartime efficiency are inseparable, so states a great military strategist. We have the weapons and the understanding to wage a real campaign on health defense, if we but have the determination and courage. "Your cooperation is most important," writes Miss Eloise Davidson, Assistant Director of the Department of Civilian Defense under the management of Mrs. Franklin D. Roosevelt speaking for the latter in a letter to the President of the Woman's Auxiliary. The letter ends as follows: "I suggest that you urge all of your members to enroll as volunteers with the local defense councils, for their leadership in the fields of nutrition and health will be most vital in the communities where they live."

"The Woman's Auxiliary has at this time a responsibility, graver than ever before, to use to the fullest extent its organization facilities for the promotion of health defense," continues the Bulletin message. "At the beginning of the current year plans were outlined for this purpose, by every department of the organization. Now that war has actually come to us, shall we not expend still further, our present program on health defense, and redouble our efforts for service to our country. Cooperate with such organizations as the American Red Cross, the local defense societies and with other national organizations, whose work in health defense is approved by the American Medical Association. Under no circumstances should the Woman's Auxiliary engage in any activity which has not been approved by the State or local advisory committee."

The Journal Of THE KANSAS MEDICAL SOCIETY

Owned and Published by The Kansas Medical Society

Volume XLIII

APRIL, 1942

Number 4

Greetings

The Sedgwick County Medical Society, together with societies from nearby counties, is afforded the distinct honor of being host to The Kansas Medical Society in its eighty-third annual session. We wish to extend to our guests and to the members of The Kansas Medical Society our most cordial welcome.

We believe you will enjoy visiting in Wichita, because the city has grown in the last two years. The exhibits, both technical and scientific, are new and will prove interesting to you. Special events, including the golf and skeet tournaments, have been provided to serve for entertainment. These are designed to supply a varied program of recreation, intended to appeal to your individual choice of activity for relaxation.

The general sessions, being of prime importance, have been planned carefully to provide you with speakers who will bring you material that will be helpful and stimulating. We consider ourselves fortunate, at a time when doctors everywhere are accepting increased responsibility, to be able to present the distinguished guests we take pride in announcing on the following pages.

In a few days after you receive this edition of the Journal, the eighty-third session of The Kansas Medical Society will convene. By that time the work of the committees will be completed and whatever has gone into the preparation shall then be given over for your instruction and pleasure. Preparing for this has been an enjoyable task, in which many persons outside the Sedgwick County Medical Society contributed. A great portion of this work has been graciously accepted by societies near us.

To all those, to everyone who shared in the responsibility of preparing for this program, we want to express our gratitude. And to you, who will visit here, we hope your stay will be profitable and pleasant.

CHARLES ROMBOLD, M.D.,

President, Sedgwick County Medical Society.

Guest Speakers

FRANK H. LAHEY, M.D.

Boston, Massachusetts

President of the American Medical Association



Graduate Harvard College, 1904. Professor of Surgery Tufts Medical School, 1913-1917, Director of Surgery, A.E.F. Evacuation Hospital No. 30, Major Medical Corps, World War; Professor of Clinical Surgery, Harvard Medical School, 1923-1924. At present—Director of Surgery, Lahey Clinic, Boston; Surgeon-in-Chief, New England Deaconess Hospital.

Member American Surgical Society, International Surgical Society; Board of Governors American College of Surgeons; member American Association for the Study of Goiter.

Chairman Procurement and Assignment Service for Personnel for Armed Forces; Honorary Medical Consultant to United States Army.

ALAN BROWN, M.D.

Toronto, Canada

Physician-in-Chief, Hospital for Sick Children, Toronto; Professor of Pediatrics, University of Toronto; Consultant Pediatrician to the Dominion, Provincial and local Boards of Health on Child Hygiene.

SPECIALTY: Pediatrics.



JOHN W. HARRIS, M.D.

Madison, Wisconsin

Professor of Obstetrics and Gynecology, University of Wisconsin; Obstetrician and Gynecologist in Chief, State of Wisconsin General Hospital; Diplomate, American Board of Obstetrics and Gynecology.

SPECIALTY: Obstetrics and Gynecology.



Guest Speakers

H. ROMMEL HILDRETH, M.D.

St. Louis, Missouri

Member Department of Ophthalmology, Washington University since 1931. Member American Academy of Ophthalmology and Otolaryngology; Chief Eye Surgeon for the Frisco Railroad.

SPECIALTY: Ophthalmology.



CYRIL M. MacBRYDE, M.D.

St. Louis, Missouri

Assistant Professor of Medicine, Washington University; Director, Metabolism Division, Barnes Hospital, St. Louis; Member Central Society for Clinical Research, Association for Study of Internal Secretions; American Diabetes Association, American College of Physicians, American Board of Internal Medicine.

SPECIALTY: Internal Medicine.

CHARLES W. MAYO, M.D.*Rochester, Minnesota*

Assistant Professor of Surgery, Mayo Foundation since 1935; Fellow of American College of Surgeons; Member American Board of Surgery.

SPECIALTY: Surgery.

**JOE VINCENT MEIGS, M.D.***Boston, Massachusetts*

Chief of the Gynecologic Service at the Massachusetts General Hospital.

SPECIALTY: Obstetrics and Gynecology.



Guest Speakers



HARRY E. MOCK, M.D.

Chicago, Illinois

Associate Professor of Surgery at Northwestern University Medical School; Senior Surgeon for St. Lukes Hospital; Chairman of the Medical Advisory Council on Health of Industrial Workers for the Office of Civilian Defense.

SPECIALTY: Surgery.



PAUL A. O'LEARY, M.D.

Rochester, Minnesota

Head of Section on Dermatology and Syphilology, The Mayo Clinic; Professor of Dermatology and Syphilology, The Mayo Foundation, University of Minnesota Graduate School.

SPECIALTY: Dermatology and Syphilology.

JOHN J. SHEA, M.D.*Memphis, Tennessee*

Fellow of the American Laryngological Association, American Otological Society, American Laryngological, Rhinological and Otological Society, American College of Surgeons, American Academy of Ophthalmology and Otolaryngology; Examiner on American Board of Otolaryngology.

SPECIALTY: Otolaryngology, Rhinology, Laryngology.

**W. D. STROUD, M.D.***Philadelphia, Pennsylvania*

Professor of Cardiology of University of Pennsylvania Graduate School of Medicine; Associate in Medicine, University of Pennsylvania School of Medicine; Cardiologist to Bryn Mawr Hospital and Director of Heart Station, Bryn Mawr, Pennsylvania.

SPECIALTY: Internal Medicine.



Member Speakers

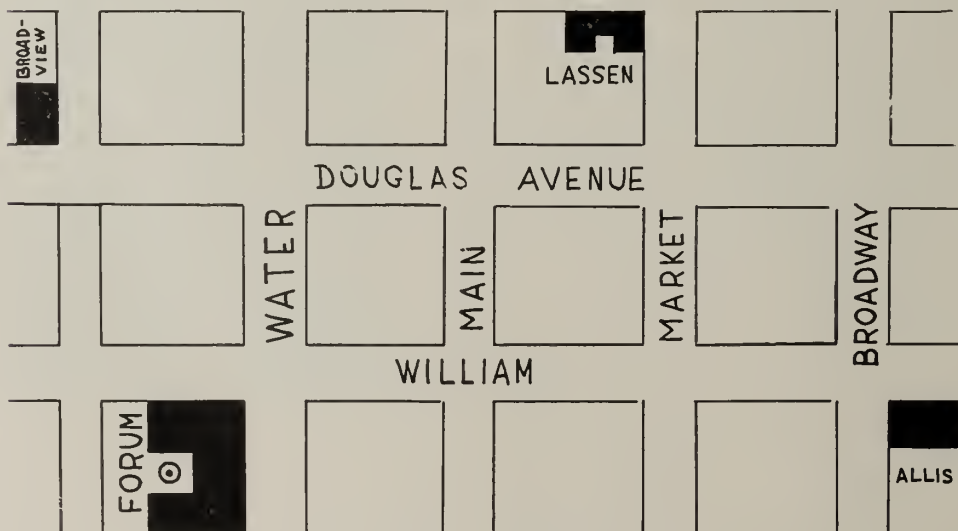
Lewis G. Allen, M.D.	Kansas City
H. O. Anderson, M.D.	Wichita
F. C. Beelman, M.D.	Topeka
Warren F. Bernstorff, M.D.	Winfield
Victor E. Chesky	Halstead
D. V. Conwell, M.D.	Wichita
E. H. Decker, M.D.	Topeka
F. L. Dennis, M.D.	Dodge City
A. C. Eitzen, M.D.	Hillsboro
Frank Foncannon, M.D.	Emporia
T. L. Foster, M.D.	Halstead
E. W. Hall, M.D.	Hutchinson
H. E. Haskins, M.D.	Kingman
James S. Hibbard, M.D.	Wichita
J. E. Hill, M.D.	Wellington
J. Allen Howell, M.D.	Wellington
H. H. Jones, M.D.	Winfield
G. E. Kassebaum, M.D.	El Dorado
J. L. Kleinheksel, M.D.	Wichita

J. L. Lattimore, M.D.	Topeka
Fred J. McEwen, M.D.	Wichita
E. A. Marrs, M.D.	Sedan
Frank L. Menehan, M.D.	Wichita
William Menninger, M.D.	Topeka
H. A. Mercer, M.D.	Arkansas City
P. G. Miller, M.D.	Anthony
N. C. Nash, M.D.	Wichita
J. H. A. Peck, M.D.	St. Francis
L. E. Peckenschneider, M.D.	Halstead
A. F. Rossitto, M.D.	Wichita
W. M. Scales, M.D.	Hutchinson
Cecil D. Snyder, M.D.	Winfield
Maurice Snyder, M.D.	Salina
Robert Sohlberg, Jr., M.D.	McPherson
D. P. Trimble, M.D.	Emporia
Marion Trueheart, M.D.	Sterling
Maurice Walker, M.D.	Kansas City
James A. Wheeler, M.D.	Newton

PLACE OF MEETING

This year again the Wichita Forum was selected as the place of meeting for the annual session of The Kansas Medical Society because of its central location and its ample space. The building is located at the intersection of Williams and Water streets, in the southwestern portion of the Wichita business district.

All events, with the exception of the round table luncheons, the alumni banquet, the house of delegates meetings, the annual banquet and the golf and trap tournaments will be held at the Forum. The locations of all special meetings are listed in the program and elsewhere, but on this map and on the preceding page you will find all places marked so they may readily be reached.



Schedule of Events

83RD ANNUAL SESSION

Wichita, May 11, 12, 13, 14, 1942

MONDAY, MAY 11

TOURNAMENT KANSAS MEDICAL GOLFING ASSOCIATION

Crestview Country Club (4400 E. 21st St.)

10:00 A. M. Practice Rounds

1:00 P. M. Competitive Golfing

TOURNAMENT KANSAS MEDICAL SKEET AND TRAPSHOOTING ASSOCIATION

Wichita Gun Club (Three miles west on Cannonball Highway)

10:00 A. M. Practice

1:30 P. M. Competitive Shooting

GOLF AND SKEET BANQUET

6:30 P. M. Crestview Country Club (4400 E. 21st St.)

Awarding of Prizes for Golf and Skeet

Election of Officers

TUESDAY MORNING, MAY 12

8:00 A. M. REGISTRATION

North Entrance of Forum — Open 8 A. M. to 6 P. M.

Opening of Scientific and Technical Exhibits

Rose Room, Forum

9:00 A. M. SHOWING OF THE MOTION PICTURE

FIRST GENERAL SESSION

Arcadia Theater, Forum

Presiding: Charles Rombold, M.D., Wichita, Kansas

9:30 A. M. SYNTHETIC ESTROGENS AND THEIR USE

Cyril M. MacBryde, M.D., St. Louis, Missouri

The history of the development of knowledge about estrogens will be briefly reviewed. The need for a synthetic, orally effective, inexpensive estrogen was recognized and eagerly sought by many workers. Dodd's announcement in 1938 of the synthesis of diethylstilbestrol gave hope that the search had been successful. Soon after this announcement my co-workers and I, as well as many other groups in this country, began clinical and experimental studies with the new drug. There is general agreement that diethylstilbestrol is a very potent estrogen capable of reproducing all of the known physiologic effects of natural estrogens. From our own studies I have selected for review 150 cases of women suffering from various types of hypogonadism, chiefly the menopausal syndrome. Criteria for selection of cases to be treated, technique of therapy and results will be discussed.

10:15 A. M. MANAGEMENT OF SKULL FRACTURE AND BRAIN INJURIES

Harry E. Mock, M.D., Chicago, Illinois

The author has made "Skull Fractures" a hobby for the last fifteen years. In 1930 he established a Skull Fracture Bureau for the purpose of collecting and analyzing the hospital records of each consecutive proved skull fracture admitted to approximately fifty hospitals of all types located in every section of the country. Skull fractures and serious head injuries occur to the extent of more than one-half million a year, and are found in every hamlet, village and city of the land. Approximately sixty-five per cent of the deaths which result from this type of injury occur in the first twenty-four hours. The wide-spread distribution and the early occurrence of death from this injury will always make this a problem for the general physician and surgeon. His paper and prompt action during the first few hours following this injury spells life or death for the patient. By surveying the case records and from many hospitals during the last twelve years, the author has been able to evaluate the results of the wide-spread publicity for better management which has filled the medical literature during the last decade.

Whereas ten years ago the mortality rates from skull fractures varied from twenty-five per cent in the hospitals with the best type of management to forty-nine per cent in hospitals where mediocre management was practiced, the author's recent survey of hospital records covering the management of 3,106 consecutive proved skull fractures shows the mortality rates now vary from seventeen per cent to forty-two per cent. His paper presents methods and means of still further reducing the mortality rate from skull fractures.

Associated injuries occur in approximately thirty-three per cent of all skull fractures. These include fractures of the vertebrae, simple and compound fractures of the extremities, multiple fractures of the ribs with and without lung injury, internal abdominal injuries, crushing injuries of the extremities requiring amputations, and many other concomitant injuries. The skull fracture mortality rate has increased from nine per cent in the author's Good Management Group to as high as forty per cent in his Poor Management Group. Confronted as we are today with the possibility of major catastrophes from enemy attack it behooves every surgeon to master the management of associated injuries in the presence of brain trauma.

11:00 A. M. INTERMISSION

11:15 A. M. FEEDING DIFFICULTIES ENCOUNTERED IN THE NEW-BORN PERIOD

Alan Brown, M.D., Toronto, Canada

A discussion of the requirements of the newborn infant, the importance of breast feeding, and the various complications arising in the neonatal period necessitating changes in diet.

12:15 P. M. -- ROUND TABLE LUNCHEONS

MEDICINE—*Lassen Hotel, Colonial Room*

Guest Speaker: Cyril M. MacBryde, M.D., St. Louis, Missouri

Presiding: Fred J. McEwen, M.D., Wichita, Kansas

SURGERY—*Allis Hotel, Empire Room*

Guest Speaker: Harry E. Mock, M.D., Chicago, Illinois

Presiding: E. S. Edgerton, M.D., Wichita, Kansas

PEDIATRICS—*Allis Hotel, Ingalls Room*

Guest Speaker: Alan Brown, M.D., Toronto, Canada

Presiding: Frank L. Menehan, M.D., Wichita, Kansas

EYE, EAR, NOSE AND THROAT—*Lassen Hotel, Basement Grill*

Guest Speakers: H. Rommel Hildreth, M.D., St. Louis, Missouri

John J. Shea, M.D., Memphis, Tennessee

Presiding: E. N. Robertson, M.D., Concordia, Kansas

TUESDAY AFTERNOON, MAY 12

SECOND GENERAL SESSION

Arcadia Theater, Forum

Presiding: Karl E. Voldeng, Wellington, Kansas

2:00 P. M. TRAUMA AND LOW BACK PAIN

Harry E. Mock, M.D., Chicago, Illinois

Many alleged back injuries and the disabilities therefrom are inherent in the patient while the trauma, often trivial, is either coincidental or plays only a minor part. The Stiller type, the effort syndrome group and the obese present real diagnostic problems when alleged trauma occurs. Again, internal abdominal injuries furnish a large field for diagnostic and differential diagnosis acumen. The treatment of certain illustrative examples will be presented with lantern slides and case reports.

2:40 P. M. KANSAS MINUTE MEN

EKG IN PROSTATIC SURGERY

Maurice Snyder, M.D., Salina

CHEMOTHERAPY IN OTITIS MEDIA

J. E. Hill, M.D., Wellington

RUPTURED INTERVERTEBRAL DISCS

J. S. Hibbard, M.D., Wichita

CALCIUM DEFICIENCY HEADACHES

Robert Sohlberg, Jr., M.D., McPherson

X-RAY PICTURE OF MASTOIDITIS FOLLOWING
SULFONAMIDE

A. F. Rossitto, M.D., Wichita

ELECTRO-SHOCK THERAPY

William Menninger, M.D., Topeka

STERILIZATION OF TRAUMATIC WOUNDS

V. E. Chesky, M.D., Halstead

ABDOMINAL ADHESIONS—NEWER THERAPY

J. H. A. Peck, M.D., St. Francis

VERTIGO

D. V. Conwell, M.D., Wichita

INSULIN TREATMENT IN CHOREA

A. C. Eitzen, M.D., Hillsboro

ADRENOCORTICAL PREPARATION IN SURGICAL SOCK

Frank Foncannon, M.D., Emporia

BRONCHIAL ASTHMA THERAPY

L. E. Peckenschneider, M.D., Halstead

THE HETEROPHILE REACTION

J. L. Lattimore, M.D., Topeka

REGENERATIVE ABILITY OF DIABETIC PANCREAS

J. L. Kleinheksel, M.D., Wichita

CHEMOTHERAPY IN PERITONITIS

H. E. Haskins, M.D., Kingman

X-RAY IN LEUKEMIA

L. G. Allen, M.D., Kansas City

SODIUM SULFAPYRIDINE IN PNEUMONIA

F. L. Dennis, M.D., Dodge City

CARE OF THE NEWBORN

J. A. Wheeler, M.D., Newton

PRACTICAL USES OF DEPROPANEX

G. E. Kassebaum, M.D., El Dorado

3:40 P. M. INTERMISSION

3:50 P. M. NUTRITIONAL PROBLEMS IN OLDER CHILDREN

Allan Brown, M.D., Toronto, Canada

A consideration of the requirements and how they may best be met, in the light of our present knowledge. This will include such subjects as intestinal indigestion, psychology of feeding, constipation, and other factors that enter into a discussion of this problem.

4:40 P. M. OBJECTIVES OF THERAPY IN DIABETES MELLITUS

Cyril M. MacBryde, M.D., St. Louis, Missouri

The use of insulin has permitted wide variation in types of diet which can be employed in the therapy of diabetes and widely differing systems of dietary management have been strongly advocated by students of the disease. In considering the merits of these various methods it is necessary to define the objectives of diabetic management so that we may ascertain whether each or all of them may be best secured by any

particular method of dietary control. The best informed opinion is in quite general agreement on these objectives, (1) freedom from symptoms; (2) freedom from ketosis; (3) adequate nutrition; (4) freedom from hypoglycemia and glycosuria of any considerable degree. As the result of our own studies, we believe another objective should be added: (5) the development of the greatest possible carbohydrate tolerance. Studies will be reported which indicate that two general groups of diabetics can be distinguished.

5:00 P. M. PRATT COUNTY MEDICAL SOCIETY ENTERTAINING

Hospitality Room, Hotel Broadview Roof Garden

6:30 P. M. KANSAS OBSTETRICAL AND GYNECOLOGICAL DINNER

Allis Hotel

Presiding: Ray A. West, M.D., President, Wichita

7:00 P. M. CUM LAUDE BANQUET

Broadview Hotel—Roof Garden

8:30 P. M. HOUSE OF DELEGATES

Allis Hotel—Empire Room

WEDNESDAY MORNING, MAY 13

8:00 A. M. REGISTRATION

North Entrance of Forum — Open 8 A. M. to 6 P. M.

Scientific and Technical Exhibits

Rose Room, Forum

THIRD GENERAL SESSION

Arcadia Theater, Forum

Presiding: Harold H. Jones, M.D., Winfield, Kansas

9:30 A. M. LESIONS OF THE COLON AND RECTUM

Frank H. Lahey, M.D., Boston, Massachusetts

The relationship of polyps and adenomas to malignancy, stressing the fact that they represent pre-cancerous stages. Discussion of diagnostic features and technical procedures influencing end results. Presentation of experiences with regional ileitis, the indications and the end results. Indications for ileostomy, partial and complete colectomy in ulcerative colitis and some of the end results obtained.

10:15 A. M. CANCER OF THE CERVIX—CHANGING CONCEPTS OF TREATMENT

Joe V. Meigs, M.D., Boston, Massachusetts

A discussion centered on the changes (from surgical treatment to radium treatment, then x-ray plus radium, now back to surgery) and results of the changes, with special consideration of the surgical treatment.

11:00 A. M. INTERMISSION

11:15 A. M. MODERN THERAPY IN CARDIOLOGY

W. D. Stroud, M.D., Philadelphia, Pennsylvania

12:15 P. M. — ROUND TABLE LUNCHEONS

MEDICINE—*Lassen Hotel, Colonial Room*

Guest Speaker: W. D. Stroud, M.D., Philadelphia, Pennsylvania

Presiding: Philip W. Morgan, M.D., Emporia, Kansas

Sponsor: Kansas Heart Society

OBSTETRICS AND GYNECOLOGY—*Allis Hotel, Empire Room*

Guest Speaker: Joe V. Meigs, M.D., Boston, Massachusetts

Presiding: Ray A. West, M.D., Wichita, Kansas

Sponsor: Kansas Obstetrical and Gynecological Society

EYE, EAR, NOSE AND THROAT—*Lassen Hotel, Basement Grill*

Guest Speakers: H. Rommel Hildreth, M.D., St. Louis, Missouri

John J. Shea, M.D., Memphis, Tennessee

Presiding: E. N. Robertson, M.D., Concordia, Kansas

WEDNESDAY AFTERNOON, MAY 13

FOURTH GENERAL SESSION

Arcadia Theater, Forum

Presiding: C. D. Blake, M.D., Hays, Kansas

2:00 P. M. PRESIDENT'S ADDRESS

C. D. Blake, M.D., Hays, Kansas

2:15 P. M. PROCUREMENT AND ASSIGNMENT OF PHYSICIANS
FOR WAR NEEDS

Forrest L. Loveland, M.D., Topeka, Kansas

2:30 P. M. THE YEAR AHEAD

Henry N. Tihen, M.D., Wichita, Kansas

2:45 P. M. ENDOMETRIOSIS

Joe V. Meigs, M.D., Boston, Massachusetts

Endometriosis is a disease of abnormal physiologic function, from the shape of the uterus, the presence of dysmenorrhea, infertility, congenital malformation of the cervix. The reason for its increase is due to the fact that late pregnancy occurs in many patients and few pregnancies lead toward the development of the celomic epithelium which early forms the müllerian ducts. The author believes that earlier marriage and more children would solve a great many of the problems of endometriosis.

3:30 P. M. INTERMISSION

3:40 P. M. THE CARDIAC PATIENT BEFORE SURGERY AND OBSTETRICS

W. D. Stroud, M.D., Philadelphia, Pennsylvania

4:25 P. M. SOME OF THE NEWER SURGICAL DEVELOPMENTS

Frank H. Lahey, M.D., Boston, Massachusetts

This paper will include (with slide illustrations) some of the results of orbital decompression in intractable exophthalmos, some of the results in the surgical treatment of hypertension and the types of cases selected for it, experiences with the employment of one hundred per cent oxygen, experiences with six hundred cases of continuous spinal anesthesia, experiences and end results with total gastrectomy, with transpleural resection of the lower end of the oesophagus and the upper end of the stomach; some of the early diagnostic features in the history of patients with cancer of the rectum and colon and end results, mortality and operability in something over twelve hundred cases; some of the unusual cases of hyperthyroidism and some of the end results in spinal accessory facial anastomosis.

7:00 P. M. ANNUAL BANQUET

Blue Moon—3401 South Oliver Street

Speaker: Frank H. Lahey, M.D., Boston, Massachusetts

Subject: MEDICAL PROBLEMS OF TODAY

10:00 P. M. DANCE

Blue Moon

Ted Fio Rito and His Orchestra

THURSDAY MORNING, MAY 14

8:00 A. M. REGISTRATION

North Entrance of Forum — Open 8 A. M. to 6 P. M.

Scientific and Technical Exhibits

Rose Room, Forum

8:30 A. M. HOUSE OF DELEGATES

Allis Hotel—Empire Room

9:00 A. M. SHOWING OF THE MOTION PICTURE

FIFTH GENERAL SESSION

Arcadia Theater, Forum

Presiding: W. P. Callahan, M.D., Wichita, Kansas

TICKETS FOR ALL SPECIAL EVENTS AVAILABLE AT TIME OF REGISTRATION

10:00 A. M. MODERN TREATMENT OF SYPHILIS

Paul A. O'Leary, M.D., Rochester, Minnesota

The so-called "five-day treatment" of early syphilis has been established as an outstanding advance in syphilotherapy. The technic, advantages, dangers and results of the procedure will be discussed. Latency, that phase of syphilis characterized by absence of clinical signs of the disease and the presence of positive serologic tests, is still a cause of concern to the physician and worry to the patient. Neurosyphilis and latent syphilis permit of a liberal discussion of various systems of treatment.

10:45 A. M. TREATMENT OF DUODENAL ULCER

Charles W. Mayo, M.D., Rochester, Minnesota

11:30 A. M. INTERMISSION

11:45 A. M. SOME PRACTICAL ASPECTS OF PAIN RELIEF IN LABOR

John W. Harris, Madison, Wisconsin

The problem of pain relief in labor presents one of the most difficult problems in physiology, especially as regards oxygen want in the fetus. The needs of both mother and child will be considered and the inherent dangers discussed. Some of the various methods of pain relief will be evaluated and a simple method for the prevention of fetal anoxia will be described.

12:15 P. M. — ROUND TABLE LUNCHEONS

MEDICINE—*Lassen Hotel, Colonial Room*

Guest Speaker: Paul A. O'Leary, M.D., Rochester, Minnesota

Presiding: J. V. Van Cleve, M.D., Wichita, Kansas

SURGERY—*Allis Hotel, Empire Room*

Guest Speaker: Charles W. Mayo, M.D., Rochester, Minnesota

Presiding: C. D. Blake, M.D., Hays, Kansas

OBSTETRICS AND GYNECOLOGY—*Allis Hotel, East Room*

Guest Speaker: John W. Harris, M.D., Madison, Wisconsin

Presiding: Ray A. West, M.D., Wichita, Kansas

Sponsor: Kansas Obstetrical and Gynecological Society

THURSDAY AFTERNOON, MAY 14

SIXTH GENERAL SESSION

Arcadia Theater, Forum

Presiding: James S. Hibbard, M.D., Wichita, Kansas

2:00 P. M. THE ECZEMA PROBLEM

Paul A. O'Leary, M.D., Rochester, Minnesota

Finding the cause of eczema becomes more and more a problem of diligent historical and clinical research. The ability to recognize the cause by its clinical appearance alone has long since vanished in the majority of the cases, so that skin tests, patch tests, trial and error are essential in eliciting the causative factor. The skin and patch tests present many loopholes, some of which will be discussed. Also the manner of seeking the offending agent and a therapeutic program for eczema in general will be discussed.

2:45 P. M. SUBSTERNAL AND INTRATHORACIC GOITRE

Charles W. Mayo, M.D., Rochester, Minnesota

3:30 P. M. INTERMISSION

3:40 P. M. RECENT ADVANCES IN THE MANAGEMENT OF TOXEMIAS OF PREGNANCY

John W. Harris, M.D., Madison, Wisconsin

The recent attempts to classify the late toxemias of pregnancy into the vascular and non-vascular types have done much to clarify their management. Early recognition of the signs and symptoms are of paramount importance. Careful follow-up studies reveal that prolonged toxemias frequently are followed by disastrous sequelae to both mother and child.

4:25 P. M. KANSAS MINUTE MEN

OBSTETRIC ANALGESIA

J. Allen Howell, M.D., Wellington

POTASSIUM THIOCYANATE IN HYPERTENSION

F. J. McEwen, M.D., Wichita

BLOOD PLASMA

Cecil D. Snyder, M.D., Winfield

EPIDERMOPHYTID REACTIONS

E. H. Decker, M.D., Topeka

SOME FACTORS IN BROMIDE INTOXICATION

T. L. Foster, M.D., Halstead

NEW DRUGS FOR ARTHRITIS

P. G. Miller, M.D., Anthony

RADIOSENSITIVITY IN VARIOUS MALIGNANCIES

Marion Trueheart, M.D., Sterling

X-RAY AND FIBROID UTERUS

N. C. Nash, M.D., Wichita

LOCAL ANESTHETIC FOR FRACTURES

H. O. Anderson, M.D., Wichita

ERYTHROBLASTOSIS

F. L. Menehan, M.D., Wichita

SULFONAMIDE IN TRACHOMA

D. P. Trimble, M.D., Emporia

G. C. CONJUNCTIVITIS

W. M. Scales, M.D., Hutchinson

ACUTE LARYNGO-TRACHEAL BRONCHITIS

W. F. Bernstorf, M.D., Winfield

TRANSURETHRAL SURGERY FOR PROSTATES

H. A. Mercer, M.D., Arkansas City

INFECTING WOUNDS—USE OF FACE MASK

Maurice Walker, M.D., Kansas City

THERAPY FOR ANGINA SPELL

H. H. Jones, M.D., Winfield

FRACTURE OF CLAVICLE

E. W. Hall, M.D., Hutchinson

PUBLIC HEALTH PROBLEMS IN KANSAS

F. C. Beelman, M.D., Topeka

COLD VACCINES

E. A. Marrs, M.D., Sedan

EYE, EAR, NOSE AND THROAT SECTION

TUESDAY, MAY 12

8:00 A. M. REGISTRATION

North Entrance of Forum — Open 8 A. M. to 6 P. M.

All meetings of the section will be in the Eye, Ear, Nose and Throat Section room.

Presiding: E. N. Robertson, Concordia, Kansas

9:30 A. M. MODERN TREATMENT OF ACUTE INFECTIONS IN OTOLARYNGOLOGY

John J. Shea, M.D., Memphis, Tennessee

10:45 A. M. INTERMISSION

11:00 A. M. DETACHMENT OF RETINA — DIAGNOSIS, MANAGEMENT AND SURGICAL RESULTS

H. Rommel Hildreth, M.D., St. Louis, Missouri

12:15 P. M. — ROUND TABLE LUNCHEONS

Lassen Hotel, Basement Grill

Guest Speakers: H. Rommel Hildreth, M.D., St. Louis, Missouri

John J. Shea, M.D., Memphis, Tennessee

Presiding: E. N. Robertson, M.D., Concordia, Kansas

2:00 P. M. HEMATOLOGY RELATIVE TO OTOLARYNGOLOGY

John J. Shea, M.D., Memphis, Tennessee

3:00 P. M. INTERMISSION

3:15 P. M. SCISSORS SECTION FOR CATARACT SURGERY

H. Rommel Hildreth, M.D., St. Louis, Missouri

WEDNESDAY, MAY 13

8:00 A. M. REGISTRATION

North Entrance of Forum — Open 8 A. M. to 6 P. M.

Presiding: E. N. Robertson, M.D., Concordia, Kansas

9:30 A. M. ANATOMY OF UPPER LID AND ITS APPLICATIONS TO SURGERY FOR PTOSIS AND OTHER ORBITAL CONDITIONS

H. Rommel Hildreth, M.D., St. Louis, Missouri

10:45 A. M. INTERMISSION

11:00 A. M. PREVENTION OF COMPLICATIONS OF TONSIL AND ADENOID SURGERY

John J. Shea, M.D., Memphis, Tennessee

12:15 P. M. — ROUND TABLE LUNCHEONS

Lassen Hotel, Basement Grill

Guest Speakers: John J. Shea, M.D., Memphis, Tennessee

H. Rommel Hildreth, M.D., St. Louis, Missouri

Presiding: E. N. Robertson, M.D., Concordia, Kansas

2:00 P. M. NERVE BLOCK ANESTHESIA FOR VARIOUS OPHTHALMIC OPERATIONS

H. Rommel Hildreth, M.D., St. Louis, Missouri

3:00 P. M. INTERMISSION

3:15 P. M. MANAGEMENT OF FRACTURES OF THE FACE

John J. Shea, M.D., Memphis, Tennessee

ROUND TABLE LUNCHEONS

At the round table luncheons this year there will be no particular topic presented. The speaker may be asked any question within his field—questions need not be confined to papers presented by the guest speakers. The round table luncheons will be held on Tuesday, Wednesday and Thursday at 12:15 to 1:30 at the places listed below.

TUESDAY

MEDICINE—*Lassen Hotel, Colonial Room*

Guest Speaker: Cyril M. MacBryde, M.D., St. Louis, Missouri

Presiding: Fred J. McEwen, M.D., Wichita, Kansas

SURGERY—*Allis Hotel, Empire Room*

Guest Speaker: Harry E. Mock, M.D., Chicago, Illinois

Presiding: E. S. Edgerton, M.D., Wichita, Kansas

PEDIATRICS—*Allis Hotel, Ingalls Room*

Guest Speaker: Alan Brown, M.D., Toronto, Canada

Presiding: Frank L. Menehan, M.D., Wichita, Kansas

EYE, EAR, NOSE AND THROAT—*Lassen Hotel, Basement Grill*

Guest Speakers: H. Rommel Hildreth, M.D., St. Louis, Missouri

John J. Shea, M.D., Memphis, Tennessee

Presiding: E. N. Robertson, M.D., Concordia, Kansas

WEDNESDAY

MEDICINE—*Lassen Hotel, Colonial Room*

Guest Speaker: W. D. Stroud, M.D., Philadelphia, Pennsylvania

Presiding: Philip W. Morgan, M.D., Emporia, Kansas

Sponsor: Kansas Heart Society

OBSTETRICS AND GYNECOLOGY—*Allis Hotel, Empire Room*

Guest Speaker: Joe V. Meigs, M.D., Boston, Massachusetts

Presiding: Ray A. West, M.D., Wichita, Kansas

Sponsor: Kansas Obstetrical and Gynecological Society

EYE, EAR, NOSE AND THROAT—*Lassen Hotel, Basement Grill*

Guest Speakers: H. Rommel Hildreth, M.D., St. Louis, Mo.

John J. Shea, M.D., Memphis, Tennessee

Presiding: E. N. Robertson, M.D., Concordia, Kansas

THURSDAY

MEDICINE—*Lassen Hotel, Colonial Room*

Guest Speaker: Paul A. O'Leary, M.D., Rochester, Minnesota

Presiding: J. V. Van Cleve, M.D., Wichita, Kansas

SURGERY—*Allis Hotel, Empire Room*

Guest Speaker: Charles W. Mayo, M.D., Rochester, Minnesota

Presiding: C. D. Blake, M.D., Hays, Kansas

OBSTETRICS AND GYNECOLOGY—*Allis Hotel, East Room*

Guest Speaker: John W. Harris, Madison, Wisconsin

Presiding: Ray A. West, M.D., Wichita, Kansas

Sponsor: Kansas Obstetrical and Gynecological Society

INFORMATION DESKS

Information desks will be established at all hotels to assist members in all way possible.

TICKETS FOR ALL SPECIAL EVENTS AVAILABLE AT TIME OF REGISTRATION

EVENTS FOR WOMEN

The Women's Auxiliary to The Kansas Medical Society extends a cordial invitation to wives of the members to attend the meetings to be held in Wichita, May 11, 12 and 13. The following is the program of events:

MONDAY, MAY 11

9:00 A. M. to 5:00 P. M.—REGISTRATION AND CREDENTIALS

North Entrance of Forum—All women, whether members of the Auxiliary or not, are requested to register.

1:00 P. M. LADIES GOLF TOURNAMENT—PRIZES

Meadowlark Golf Club, 4611 E. Harry Street

TUESDAY, MAY 12—Friendship Day

9:00 A. M. to 5:00 P. M.—REGISTRATION AND CREDENTIALS

Forum

9:30 A. M. PRE-CONVENTION BOARD MEETING

Lassen Hotel, Aeronautics Room

2:00 P. M. FRIENDSHIP BRIDGE

Lassen Hotel, Aeronautics Room—Door Prizes

7:00 P. M. FRIENDSHIP BANQUET

Allis Hotel, Crystal Ballroom

Program: Radio Broadcast, "The Woman's Hour"

Speaker: Mrs. F. Haggard, San Antonio, Texas, President-Elect, Woman's Auxiliary, American Medical Association

WEDNESDAY, MAY 13

9:00 A. M. to 12:00 Noon—REGISTRATION AND CREDENTIALS

Forum

9:30 A. M. GENERAL SESSION

Allis Hotel, Ingalls Room—Election of State Officers

Speakers: Mrs. F. Haggard, San Antonio, Texas

Mr. Clarence G. Munns, Topeka, Kansas

1:00 P. M. LUNCHEON

Innes Tea Room, Colonial Room

Program: Installation of State Officers

Speakers: C. D. Blake, M.D., Hays, Kansas, President, The Kansas Medical Society

H. N. Tihen, M.D., Wichita, Kansas, President-Elect, The Kansas Medical Society

C. Omer West, M.D., Kansas City, Kansas, Chairman, Auxiliary Committee of The Kansas Medical Society

Style Show—Summer Fashions

3:30 P. M. POST-CONVENTION BOARD MEETING

Allis Hotel, Ingalls Room

7:00 P. M. ANNUAL BANQUET

The Blue Moon—The Kansas Medical Society

10:00 P. M. DANCE

The Blue Moon—Ted Fio Rito and His Orchestra

PRESIDENT'S MESSAGE

When this Journal reaches you, our thoughts and plans will be focused on the State meeting in Wichita. The Auxiliary program will be held in two days, May 12 and 13, instead of three, as originally planned. Every session will be of vital interest to each member and to all visitors. The program will be printed in this Journal and also in the April Newsletter. Please bring it with you for reference as we will have no separate programs. Our National President-Elect will be with us and she will be full of plans for the coming years work. If we believe that our organization is "a fixed and lasting obligation" to organized medicine and to our Kansas doctors, we will not shirk the responsibility of our continuous attendance at all the sessions.

Mrs. J. W. Cheney, President of the Sedgwick County Auxiliary and Chairman of general arrangements, has with her loyal membership of 112, been planning all through the year for your comfort and pleasure. We hope that every auxiliary will send its full quota of delegates and as many others as they possibly can.

Besides our national officers, we will have some splendid guest speakers on Wednesday, Mr. Clarence G. Munns, Dr. C. Omer West, Dr. C. D. Blake and Dr. H. N. Tihen. Come with a receptive mind to the business meeting which really portrays the activities of our Auxiliary.

MRS. W. Y. HERRICK

At the beginning of my term of office I pledged my best efforts to this goal: "To build on the foundation of yesterday with the tools of today the better medical world of tomorrow." To whatever extent this has been achieved most of the credit goes to your friendly and faithful cooperation: To the continued interest and unselfish service rendered the Auxiliary by Dr. Blake and Dr. West. Words are futile when I attempt to express my appreciation of their inspiring and constructive assistance. We also owe a debt of gratitude to the office force of The Kansas Medical Society in Topeka. They have cheerfully complied with my every request and sometimes even before I have had the courage to express my wants.

There are difficult days ahead of us and there will be those who will even suggest that we give up our Auxiliary for the time being. If there were ever a need for our united efforts it is now. If we desire to do our part toward the preservation of the high standards of medicine, it is now. It will be only through our alert and intelligent unity of purpose that we will obtain any degree of success.

It is difficult to think straight in these crooked times and there is a great deal of loose thinking in the world today because much of it is the result of emotional reaction. Let us think this thing through and hold fast to that which is good.

As I say farewell, I pledge my continued interest and my full cooperation with the new officers and the board of managers for 1942-1943.

Mrs. W. Y. Herrick.

PRESIDENT-ELECT'S MESSAGE

"Every Doctor's Wife in Health Defense" is our slogan for the coming year. "Defense" is the most popular word of our present day vocabulary and it is only natural that doctors' wives should be interested in the "Health" angle.

This country was founded so that we could enjoy "life, liberty and the pursuit of happiness," but would any of this be possible without health? Now that these fundamental rights are threatened it is more important than ever that the health of the country be improved so these rights may be protected.

An organized group, such as the Woman's Auxiliary to The Kansas Medical Society, can do an effective piece of defense work in the year to come. Let us devote our energies to making America healthier than it has ever been before.

Mrs. C. Omer West.



MRS. C. OMER WEST

SCIENTIFIC MOVIES

The following scientific movies will be shown in the Movie Room at the Forum at the time indicated.

TUESDAY, MAY 12

- 9:00 A. M. COMPLETE LACERATION OF THE PERINEUM—15 min.
- 9:30 A. M. COLLAPSE THERAPY—30 min.
- 10:15 A. M. TRANSVERSE CERVICAL CESAREAN SECTION—18 min.
- 11:15 A. M. CANCER OF THE FEMALE BREAST, DIAGNOSIS AND TREATMENT—40 min.
- 2:00 P. M. SEX HORMONES—PHYSIOLOGY, DIAGNOSIS, THERAPY—56 min. (Sound)
- 3:50 P. M. TREATMENT OF EMPYEMA—32 min.

WEDNESDAY, MAY 13

- 9:00 A. M. ANDROGENIC TUMOR OF THE ADRENAL—15 min.
(By Nelse Ockerblad, M.D., Kansas City, Mo.)
- 9:30 A. M. NICOTINIC ACID DEFICIENCY—35 min.
- 10:15 A. M. RIBOFLAVIN DEFICIENCY—35 min.
- 11:15 A. M. MANCHESTER OPERATION FOR UTERINE PROLAPSE—25 min.
- 2:45 P. M. THIAMINE CHLORIDE DEFICIENCY—25 min.

THURSDAY, MAY 14

- 9:00 A. M. PURPOSEFUL SPLINTING—15 min.
- 9:15 A. M. CHOOSE TO LIVE—15 min. (American Society for Control of Cancer)
- 9:30 A. M. PURPOSEFUL SPLINTING—15 min.
- 9:40 A. M. ENEMY X—18 min. (American Society for Control of Cancer)
- 10:00 A. M. MODIFIED TECHNIC FOR REPAIR OF INGUINAL HERNIA—15 min.
(By M. J. Rumold, M.D., Kansas City, Mo.)
- 10:45 A. M. ROENTGEN PELUIMETRY—28 min.
- 11:45 A. M. APPLICATION OF THICK SPLIT SKIN GRAFTS—30 min.
- 2:00 P. M. *Request Repeats*

NOTE—Acknowledgement is made to the following firms who so kindly permitted the use of movie: Eli Lilly and Company; Davis and Geck, Inc.; Mead Johnson and Company; and Parke Davis and Company.

HOSPITALITY ROOM

TUESDAY, MAY 12, 5:30 P. M.

Roof Garden, Broadview Hotel

The Pratt County Medical Society will be host at an hour of friendship and good cheer on the Roof Garden of the Broadview Hotel on Tuesday, May 12, at 5:30 P. M. At the close of a busy and active day, our good friends and neighbors of Pratt County welcome all delegates and guests to an hour's pause for recreation. During this interval we shall meet our friends in an informal way and incidentally shall prepare ourselves to be in a receptive mood for the program to follow.

HOUSE OF DELEGATES

The meeting of the House of Delegates will be held on Tuesday, May 12 at 8:30 P. M. at the Allis Hotel, and on Thursday, May 14, at the Allis Hotel at 8:30 A. M. The first regular meeting will be devoted to the reports of officers, councilors, committees and other business. The second regular meeting will include the annual election of officers and the completion of unfinished business.

The reference committee plan utilized last year will again be used and is believed will save a considerable time in the handling of the proceedings of the House of Delegates. A reference committee on reports of officers and councilors and one on committee reports and resolutions will be appointed, and will receive and consider resolutions and the reports of officers, councilors and committees in advance of the first meeting of the House of Delegates. The reference committees will then present recommendations to the House of Delegates concerning the adoption of reports and resolutions. Likewise resolutions and new business introduced at the first regular meeting of the House of Delegates may be referred to these committees for presentation and recommendation at the second meeting.

A reserved section will be provided at the House of Delegates meeting place for the seating of delegates. Delegates will be registered at the entrance of the meeting place which will entitle them to sit in the reserved section. It is thought that this arrangement will eliminate the necessity for roll calls, and that it will thereby expedite the voting. Delegates are requested to present letters of authority or other certifications from their county medical societies.

The Constitution and By-Laws provides that each county medical society shall be entitled to send to the House of Delegates each year, one duly qualified Delegate for every twenty members, and one duly qualified Delegate for each major fraction thereof; provided that each component society has made its annual report and paid its assessments as provided in the Constitution and By-Laws. In the event that a Delegate finds it impossible to attend, the By-Laws provide that he shall appoint an Alternate to attend and serve in his place and that each such Alternate shall qualify himself to the committee on credentials.

Many matters of extreme importance are scheduled upon the agenda for this year's House of Delegates meetings, and every county medical society is urged to have its Delegates or Alternates present at both of the meetings.

All members of the Society are invited to attend the meetings of the House of Delegates.

REGISTRATION

The Constitution and By-Laws of the Society provide that every physician must register before he shall be entitled to attend any of the events of the meeting. The only requirement for registration is the presentation of a 1942 Society membership card. Registration by any other means requires certification by the secretary of the county medical society of place of residence, or by an officer of the Society.

The registration headquarters will be located at the entrance of the Wichita Forum and will be open from 8:00 A. M. to 6:00 P. M. each day. Tickets for the annual banquet, the "Cum Laude" banquet, and the round table luncheons may be obtained at the registration desk.

PAGE SERVICE

A group of Boy Scouts will be on duty each day to serve as pages and to facilitate in handling telephone calls and urgent communications. Special screens and lanterns will be placed in each section meeting room and names of physicians to be paged will be thrown upon the screens, thus eliminating confusion during the meeting. Members expecting calls are requested to notify the registration desk.

SCIENTIFIC EXHIBITS

It is believed that the scientific exhibits scheduled for the 83rd Annual Session, under the supervision of the Cowley County Medical Society, will be of interest to all members. The exhibits will be open from 8:00 A. M. to 6:00 P. M. daily.

EXPERIMENTAL STUDIES IN BRUCELLOSIS

Fred Angle, M.D., Dorothy Morgan, M.D., The University of Kansas School of Medicine, Kansas City, Kansas

CLINICAL CONTROL OF DIGITALIS

Graham Asher, M.D., The University of Kansas School of Medicine, Kansas City, Kansas

X-RAY EXHIBIT FROM THE STATE SANATORIUM FOR TUBERCULOSIS

C. F. Taylor, M.D., State Sanatorium for Tuberculosis, Norton, Kansas

CLINICAL USE OF TESTOSTERONE PROPIONATE

Henry H. Turner, M.D., Oklahoma City, Oklahoma

SKULL CHANGES IN NEUROLOGICAL DISEASES

Ralph M. Stuck, M.D., Denver, Colorado

SURGICAL TREATMENT OF PROGRESSIVE DEAFNESS

Laverne B. Spake, The University of Kansas School of Medicine, Kansas City, Kansas

HEMATOGENOUS OSTEOMYELITIS, EXPERIMENTAL, CLINICAL AND IMMUNOLOGICAL STUDIES

James B. Weaver, M.D., The University of Kansas School of Medicine, Kansas City, Kansas

SURGICAL TREATMENT OF HYPERTENSION

Cecil D. Snyder, M.D., Winfield, Kansas

FACTS ABOUT WORKMEN'S COMPENSATION OF INTEREST TO INDUSTRIAL SURGEONS

Erskine Wyman, Workmen's Compensation Commissioner, Topeka, Kansas

AUTOMOBILE ACCIDENTS AND FRACTURES

H. M. Glover, M.D., Chairman, Committee on Automobile Accidents and Fractures of The Kansas Medical Society, Newton, Kansas

THE HANGING CAST IN TREATMENT OF FRACTURES OF THE HUMERUS

R. S. Griswold, M.D., Louisville, Kentucky

EXTRA-ARTICULAR FIXATION IN TREATMENT OF FRACTURES OF THE UPPER EXTREMITY OF THE FEMUR

Howard E. Snyder, M.D., Winfield, Kansas

EXHIBIT BY THE AMERICAN RED CROSS

National Office, American Red Cross

BOY SCOUTING—HEALTH AND SAFETY—EMERGENCY SERVICE

Region Eight Boy Scouts of America, Harold W. Lewman, Regional Scout Executive, Kansas City, Missouri

PATHOLOGY OF THE KIDNEY

H. R. Wahl, M.D., The University of Kansas School of Medicine, Kansas City, Kansas

MEDICO-LEGAL PATHOLOGY

C. Alexander Hellwig, M.D., Wichita, Kansas

CHRONIC CYSTIC MASTITIS

H. Lester Reed, M.D., Wichita, Kansas

RADIATION TREATMENT OF CANCER

M. Trueheart, M.D., Sterling, Kansas

LIPOMA OF THE STOMACH

M. J. Rumold, M.D., The University of Kansas School of Medicine, Kansas, City, Kansas

ASEPTIC GASTRO-INTESTINAL REACTION

James S. Hibbard, M.D., Wichita, Kansas

CANCER CONTROL POSTERS

Kansas Division of the Women's Field Army of the American Society for the Control of Cancer

CANCER CONTROL IN KANSAS

Kansas State Board of Health, Topeka, Kansas

LOCAL HEALTH SERVICE

Kansas State Board of Health, Topeka, Kansas

THE KANSAS VETERINARY MEDICAL SOCIETY

Kansas Veterinary Medical Society, J. A. Bogue, D.V.S., Wichita, Kansas

PORTRAITS OF IMPORTANT PERSONAGES IN THE HISTORY OF ANATOMY AND MEDICINE

Henry C. Tracy, Anatomy Department, University of Kansas, Lawrence, Kansas

PIONEERS IN KANSAS MEDICINE

Elvenor Ernest, M.D., Topeka, Kansas

EXHIBITS OF THE WOMEN'S AUXILIARIES TO THE MEDICAL SOCIETY

Mrs. Gerard C. Unrein, Hays, Kansas

COMMITTEE CHAIRMEN

The Medical Societies of Sumner, Pratt and Cowley Counties have assisted the Sedgwick County Medical Society in planning and preparing the 83rd Annual Session.

Serving as general chairman is J. S. Reifsneider, M.D. Chairman of the various committees are G. E. Milbank, M.D., Treasurer; C. H. Warfield, M.D. (now on active duty with U.S.N.R.); E. H. Terrill, M.D., Acting Chairman, Arrangements; George Gsell, M.D., Scientific Program; H. E. Snyder, M.D., Winfield, Scientific Exhibits; J. V. Van Cleve, M.D., Entertainment (N. L. Rainey, M.D., Golf; G. B. Morrison, M.D., Skeet; R. H. Maxwell, M.D., "Cum Laude" Banquet; W. J. Kiser, M.D., Annual Banquet); A. E. Hiebert, M.D., Technical Exhibits; C. C. Brown, M.D., Registration; L. A. Donnell, M.D., Publicity.

TECHNICAL EXHIBITS

As all members know, no greater contribution is made to a state medical meeting than that furnished by the technical exhibitors. The financial assistance provided by the exhibitors in their purchase of exhibit space makes it possible to provide a type of meeting which would otherwise be difficult or impossible, and the display of new equipment and new products affords an important scientific contribution. In return for this assistance, the exhibitors appreciate an opportunity to explain the services their companies are able to offer. Kansas has been fortunate in the number of exhibitors that it is able to obtain. It would like very much to have every exhibitor feel that he is fully paid for the considerable expense his exhibit represents. Members can, therefore, assist in fulfilling an obligation and in making possible even bigger and better Kansas meetings—by visiting and registering at each exhibit.

Booth 1

MEAD JOHNSON AND COMPANY

Evansville, Indiana

"'Servamus Fidem' means We Are Keeping the Faith. Almost every physician thinks of Mead Johnson and Company as the maker of Dextri-Maltose, Pabulum, Oleum Percomurphum, and other infant diet materials. But not all physicians are aware of the many helpful services this progressive company offers physicians. A visit to Booth No. 1, will be time well spent."

* * *

Booth 2

PHILIP MORRIS AND COMPANY, LTD.

New York, New York

"Philip Morris and Company will demonstrate the method by which it was found that Philip Morris Cigarettes, in which diethylene glycol is used as the hygroscopic agent, are less irritating than other cigarettes. Their representative will be happy to discuss research on this subject, and problems on the physiological effects of smoking."

* * *

Booth 3

THE BORDEN COMPANY

New York, New York

"For all the news about Borden's scientifically designed infant foods, visit Booth No. 3. Biolac (liquid modified

milk) fully satisfies all nutritional requirements of early infancy except vitamin C. New improved Dryco (with quicker solubility and increased potencies of vitamins A and D) offers maximum formula flexibility to meet varying nutritional needs. Mull-soy is an exceptionally palatable and readily digestible emulsified food for infants allergic to milk. Other outstanding infant foods include Beta Lactose, Klim, Merrell-soule Powdered Milks, and Borden's Silver Cow Irradiated Evaporated Milk."

* * *

Booth 4

THE W. E. ISLE COMPANY

Kansas City, Missouri

"The W. E. Isle Company of Kansas City, Missouri, invite each registrant to their booth. Well informed representatives will gladly discuss the newer appliances and furnish information about the products displayed. Artificial limbs, orthodaedic appliances, surgical supports, maternity belts, elastic hosiery, trusses—you prescribe one or more of these articles frequently. Take this opportunity to examine the complete line of Isle products."

* * *

Booth 6

AMERICAN OPTICAL COMPANY

Kansas City, Missouri

"Permit us to demonstrate our new No. 2390 trial frame.





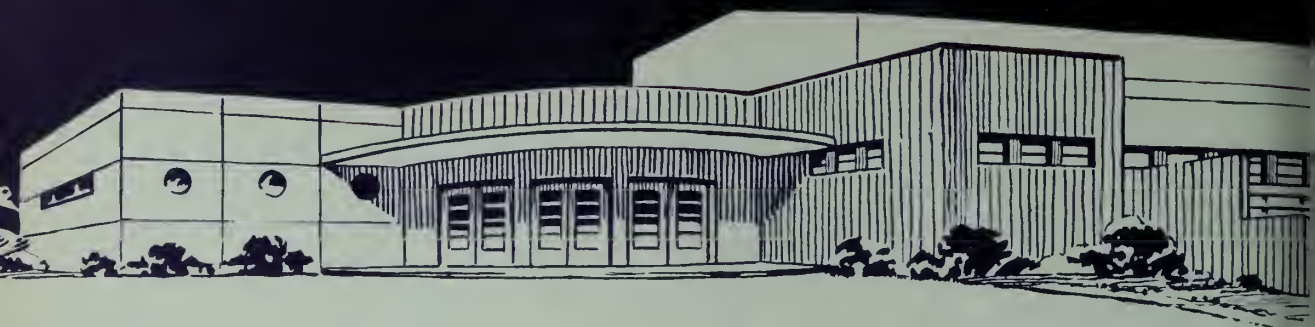
FRANK H. LAHEY, M. D., *Speaker*
BOSTON, MASS.
President American Medical Assn.

Attend the
ANNUAL BANQUET
of the 83rd Annual Session
KANSAS MEDICAL SOCIETY



CLYDE D. BLAKE, M. D., *President 1942*
HENRY N. TIHEN, M. D., *President 1943*

WICHITA'S SWA



THE ANNUAL BANQUET

will be held at the

BLUE MOON, Wichita

Program

Dinner-Dance 7:00 p.m.

Dinner Music Verne Nydegger and His Orchestra

Introduction of Honored Guests

Presiding Clyde D. Blake, M.D., *President*

Speaker:

Frank H. Lahey, M.D.

Boston, Massachusetts

President of The American Medical Association

Subject:

Medical Problems of Today

*Buy banquet tickets when you register and
inquire at that time about transportation.*

NIGHT SPOT



Then Dance with **TED FIO RITO** *and* *His Famous Orchestra*

Reserved this night for You and Your guests.

The largest night spot west of Chicago.

Outdoor or indoor beautiful dance floors.

Air conditioned, cool, quiet, restful.

Tables for everyone—more than enough room.

Come as you like, formal or informal.

DANCE

VISIT

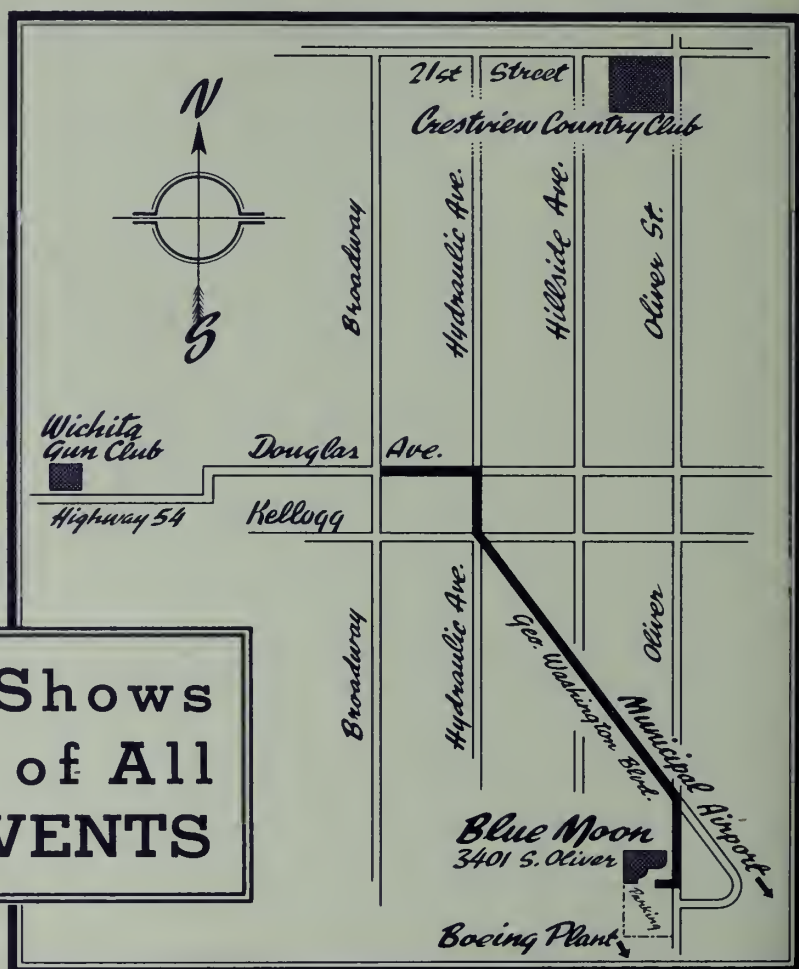
LISTEN

WEDNESDAY — MAY 13th — 7:00 p.m.

Mark this Date on Your Calendar

MAY 13
7:00 p.m.

**This Map Shows
Locations of All
SPECIAL EVENTS**



One of the three Blue Moon Pavilions



This trial frame has all the good features of previous models and a number of new features of its own. Patented aligning device, which is absolutely necessary to determine effective power with trial lenses, permits accurate determination of the corneal position by the gun sight method. It has three rotating cells in the front and a stationary spherical cell in back. All gears are totally enclosed, eliminating any danger of dust or dirt getting in, or the gears catching in the patient's hair. The frame is constructed of special metal, selected for its extreme lightness and strength. Pupillary adjustment can be independently obtained for each eye. The bridge and cells may be easily locked in any position."

Booth 7

THE MENNEN COMPANY

Newark, New Jersey

"The Mennen Company will exhibit their two baby products—antiseptic oil and antiseptic borated powder. The antiseptic oil is now being used routinely by more than ninety per cent of the hospitals that are important in maternity work. Be sure to register at the Mennen exhibit and receive your kit containing demonstration sizes of their shaving and after-shave products; also, for the lucky number prize drawing to be held at the close of the Convention for the DeLuxe Fitted Leather Toilet Kits."

Booth 9

ABBOTT LABORATORIES

North Chicago, Illinois

"A hearty welcome awaits you here and the Abbott-trained representatives in attendance are anxious to exchange notes with you on the newer specialties shown. Featured in this exhibit are Nembutal, Nembutal-C, a wide range of vitamins including ascorbic acid, nicotinic acid, riboflavin, thiamine, Natopherol, Klotogen, Hykinone, Kay-quinone, Pantothenate, multi-vitamin products, etc., arsenical, intravenous solution and Venoclysis equipment and a rather comprehensive selection of Abbott specialties. "Be sure to come in and visit us!"

Booth 10

THE MID-WEST SURGICAL SUPPLY COMPANY, INC.

Wichita, Kansas

"Booth No. 10 will be occupied by the Mid-West Surgical Supply Company. Cy Jennings and Fay Martin expect to be in attendance, to thank friends for their splendid patronage, during the past year."

Booth 11

HOLLAND-RANTOS COMPANY, INC.

New York, New York

"Modern contraceptive technique will be graphically illustrated with a motion picture, and all the various contraceptive materials including both the Koromex and Hyva diaphragms, Koromex jelly and H.R. Emulsion cream, together with the most complete line of contraceptive specialties, will be demonstrated at the Booth of the Holland-Rantos Company. Displayed also, will be the new Rantex Surgical Masks and Caps, now being used by hospitals all over the country. They represent an outstanding development."

Booth 14

SMITH, KLINE AND FRENCH LABORATORIES

Philadelphia, Pennsylvania

"We welcome this opportunity to display our products, including Benezdrine Inhaler, Benezdrine Sulfate Tablets, 'Paredrine Hydrobromide Aqueous' and Pentaplex, to the members of the Society. Our representative will be only too glad to discuss the products exhibited and will endeavor to answer any questions that may arise concerning them."

Booth 15

PARKE, DAVIS AND COMPANY

Detroit, Michigan

"Featured in the Parke-Davis Exhibit will be the sex hormones, Theelin and Theelol; antisiphilitic agents, such as Mapharsen and Thio-Bismol; posterior lobe preparations,



including Pituitrin, Pitocin and Pitressin; and various ad-renaline chloride preparations."

Booths 17 and 18

PET MILK SALES CORPORATION
St. Louis, Missouri

"An actual working model of a milk condensing plant in miniature will be exhibited by the Pet Milk Company in Booth Nos. 17 and 18. This exhibit offers an opportunity to obtain information about the production of Irradiated Pet Milk and its uses in infant feeding and general dietary practice. Miniature Pet Milk cans will be given to each physician who visits the Pet Milk Booth."

Booth 19

THE MEDICAL PROTECTIVE COMPANY
Fort Wayne, Indiana

"The most exacting requirements of adequate liability protection are those of the professional liability field. The Medical Protective Company, specialists in providing protection for professional men, invites you to confer, at their exhibit, with the representative there. He is thoroughly trained in professional liability underwriting."

Booth 20

S. H. CAMP AND COMPANY
Jackson, Michigan

"S. H. Camp and Company of Jackson, Michigan, will show a series of anatomical drawings by Tom Jones as the central theme of their exhibit. There will be included also a display of the anatomical supports carried by the company's authorized dealers who are equipped to serve patients for the various supports prescribed by physicians for prenatal, postnatal, hernial, sacro-iliac, lumbosacral, visceroprotosis and other specific conditions. Experts from the Camp staff will be in attendance to answer questions."

Booth 21

GREB X-RAY COMPANY
Kansas City, Missouri

"Our Mr. Gordon Greb will be on hand to welcome you and, should you be interested in x-ray equipment, be happy to have the opportunity to explain the advantages and superior qualities of Picker-Waite apparatus to you."

Booth 23

CEROPHYL LABORATORIES, INC.
Kansas City, Missouri

"Cerophyl Laboratories will have on display photographic records of vitamin experiments which are both timely and interesting. Now that the nation's attention is centered on proper nutrition and corrective diets, you will not want to miss this exhibit. A cordial invitation is extended to visit them at Booth No. 23."

Booth 24

H. G. FISCHER AND COMPANY
Chicago, Illinois

"The best way to look at an x-ray apparatus is with an x-ray. You have to get under the finish. It's down there that the real difference lies. To every visitor at the convention of The Kansas Medical Society, accordingly, we give this special invitation: Look under the finish of the new Fischer models of apparatus shown: Fischer shock-proof x-ray apparatus, short wave units, ultra violet and other generators are built both for performance and to

stand the very hardest day by day usage. Demands to be shown the real under-the-finish facts about Fischer models."

Booth 25

M. & R. DIETETIC LABORATORIES, INC.
Columbus, Ohio

"M. & R. Dietetic Laboratories, Inc., Booth No. 25, will display Similac, a food for infants deprived partially or entirely of breast milk, also powdered SofKurd. Representatives will appreciate the opportunity to discuss the merit and suggested application of these products."

Booth 26

GERBERS PRODUCTS COMPANY
Fremont, Nebraska

"The complete line of Gerber Foods will be on display—two dry, precooked Cereals (one a wheat cereal, the other an Oatmeal which is wheat-free), eighteen Strained Foods and ten Junior or Chopped Foods. Booklets available for distribution to mothers or to patients on special diets as well as the professional literature all of which will be sent to registrants."

Booth 27

PETROGALAR LABORATORIES, INC.
Chicago, Illinois

"This year Booth No. 27, will be occupied by Petrogalar Laboratories, Inc., who offer, in addition to samples of the Five Types of Petrogalar, an interesting selection of descriptive literature and anatomical charts. Ask the Petrogalar representative to show you the Habit Time booklet. It is a welcome aid for teaching bowel regularity to your patient."

Booth 28

BURROUGHS WELLCOME & COMPANY (U.S.A.), INC.

New York, New York

"Burroughs Wellcome and Company (U.S.A.), Inc., New York, presents a representative group of fine chemicals and pharmaceutical preparations, together with new and important therapeutic agents of special interest to the medical profession."

Booth 30

C. B. FLEET COMPANY, INC.
St. Louis, Missouri

"Phospho-Soda (Fleet) has been an ethical product for over half a century. It is composed of the two U.S.P. phosphates employed in just the right proportions to produce the maximum therapeutic effects of sodium phosphate. We feel that its ease of administration, purity, palatability, activity, and mildness in action, warrants its use over the other forms of sodium phosphate. We are offering to the profession the most elegant preparation that constitutes a high degree of pharmacal chemistry. Phospho-Soda (Fleet) is chiefly indicated in conditions where a mild eliminating and hepatic agent is desired."

Booth 31

E. R. SQUIBB AND SONS
New York, New York

"E. R. Squibb & Sons, located in Booth No. 31, will endeavor to convey scientific and pertinent information about some of their most important products by striking visual methods. Numerous photographs, charts, and demonstration packages will graphically point up the important features of these products, among which will be included

new additions to their vitamin, glandular and specialties lines. Well informed representatives will be on hand, moreover, to welcome visitors and to furnish further information on the products displayed."

Booth 32

GENERAL ELECTRIC X-RAY CORPORATION
Kansas City, Missouri

"In view of the situation existing now, due to the government's need for x-ray equipment, we do not feel it justifiable, or even possible, to take out of circulation for exhibit purposes, equipment needed for government and private orders. For this reason, we will this year show only smaller equipment and supply items that are available. Mr. Falk and Mr. Liscum, our two Kansas representatives, will be at the meeting and will be glad to meet you all and discuss with you your equipment needs."

Booth 33

A. J. GRINER COMPANY
Kansas City, Missouri

"A. J. Griner Company will display, laboratory supplies, clinical equipment, microscopes, item of special interest is the new micro-film reader, as well as the Kahn shaking machine, new all-metal incubators, photoelectric colorimeters, etc. Any problem of equipment can be taken up with representatives at our booth. Trained men will preside."

Booth 34

THE W.M. S. MERRELL COMPANY
Cincinnati, Ohio

"Diothoid, a new suppository for relief of pain in hemorrhoids and other ano-rectal conditions, will be featured at the Merrell exhibit, together with Beta-Concemin, Nitranitol, and other Merrell prescription specialties of outstanding usefulness. You are cordially invited to stop by for a discussion of these with Merrell representatives."

Booth 35

DAIRY COUNCIL OF WICHITA
Wichita, Kansas

"The Wichita Dairy Council is sponsored by the Wichita Milk Producers Association and the following pasteurizing dairies: DeCoursey Cream Company, Hyde Park Dairies, Meadow Gold Products Company, Snyder Ice Cream Company, Steffen Ice and Ice Cream Company and the Superior Dairy. The Booth of the Wichita Dairy Council will contain a cross section of Nature's Greatest Food-Factories—the dairy cow, making man's most nearly perfect food—milk. Of special interest to the medical profession will be the health education and nutritional material, much of it written especially for doctors and many pieces containing the seal of acceptance of the American Medical Association Council on Foods. The National Dairy Council was organized in 1918 with forty local councils, for the purpose of education to 'promote optimum health and human welfare through adequate use of milk and its products in accord with scientific recommendations.' Don't fail to visit the Wichita Dairy Council Booth."

Booth 37

AMERICAN HOSPITAL SUPPLY CORPORATION
Chicago-New York

"You will see interesting demonstrations of the ease, rapidity, and economy of plasma preparation with Bax-

ter equipment, by both centrifugation and sedimentation methods. You will also have an opportunity to learn about the latest transfusion methods, and the merits of the Baxter Sulfanilamide and Alcohol-Dextrose solutions, two new products which have made an excellent therapeutic record. Also on display are new and exclusive American products and equipment, which have been the subject of so much favorable comment by the profession."

Booth 39

QUINTON-DUFFENS OPTICAL COMPANY
Topeka-Hutchinson-Salina

"Marshall Becker, Bob Duffens and Art Busche will be in attendance at Booth No. 39."

Booths 40 and 41

CAMEL CIGARETTES
New York, New York

"Camel Cigarettes will exhibit large detailed photographs of equipment used in comparative tests of the five largest-selling brands of cigarettes. These tests proved that Camels burn slower and contain less nicotine in the smoke than other cigarettes. Representatives will be available to discuss this research."

Booth 42

ORTHO PRODUCTS, INC.
Linden, New Jersey

"The Ortho Products exhibit features the scientific background of Ortho-Gynol, Ortho-Cream, and Ortho Diaphragms. Physicians are invited to discuss with our representative the uses and effectiveness of our products. Ask for reprints of published reports on clinic studies of modern methods of contraception."

Booth 43

ARCHER-TAYLOR DRUG COMPANY
Wichita, Kansas

"The Archer-Taylor Drug Company display will consist exclusively of our own line of pharmaceuticals and specialties. Sam H. Archer, president and Don W. Moore, southern Kansas representative of the company will be on hand to greet new and old friends. We have something of interest for your consideration. While in Wichita plan to visit our Booth No. 43 and also the laboratories, located at 700 North Main Street. You are cordially invited."

Booth 45

RIGGS OPTICAL COMPANY
Kansas City, Missouri

"Physicians are invited to see the Riggs Optical Company's display in Booth No. 45. The newest in eyewear in Frames, mountings, and lenses as well as diagnosis instruments."

Booth 46

A. S. ALOE COMPANY
St. Louis, Missouri

"A. S. Aloe Company cordially invited you to visit Booth No. 46. They will have on display a complete line of American-made stainless steel surgical instruments, surgical supplies, laboratory apparatus and physical therapy equipment. Many new and exclusive items will be shown. Mr. Max M. Coe will be in attendance."

Booth 47

JOHN WYETH AND BROTHERS, INC.

Philadelphia, Pennsylvania

"Members are cordially invited to visit Booth No. 47, where the representatives of John Wyeth & Brothers, Inc., will exhibit their pharmaceutical specialties."

Booth 48

CARNES ARTIFICIAL LIMB CORPORATION

Kansas City, Missouri

"A new exhibitor at the annual meeting this year will be the Carnes Artificial Limb Corporation of Kansas City, Missouri, manufacturers of mechanical artificial arms and legs. This company has devoted over forty years to the rehabilitation of persons suffering amputations. There are over ten million dollars worth of Carnes limbs in use in the United States and more than three million dollars worth in use in foreign countries. The company was quite active at the end of the last World War in the rehabilitation of soldiers for all the Allied Nations. You are cordially invited to stop at the Carnes Booth at the meeting where prosthetic appliances will be demonstrated. Their lifelike appearance, usefulness and quality will be most interesting to you."

Booth 49

J. R. SIEBRANDT MANUFACTURING COMPANY

Kansas City, Missouri

"The Goodwin Bone Clamp simplifies the technique for open reduction of long bone fractures. With this clamp, the bones are easily aligned, and when wiring fractures, the entire operation from drilling holes to the tightening of the wires, is all done with this instrument and a few accessories. It is made with two separate jaws to enable the surgeon to use lower jaw as a gouge, to reduce trauma. The drill guide and calibrated lock stem control direction and depth of drilling, indicates the diameter of bone, and calculates the correct length of screw to use for applying bone plates. See this clamp and a complete line of bone instruments and fracture appliances in Booth No. 49, which will be occupied by the J. R. Siebrandt Manufacturing Company of Kansas City, Missouri."

Booth 51

DAVIS & GECK, INC.

Brooklyn, New York

"Davis and Geck, Inc., will display its complete line of sterile sutures including . . . Fine Gauge (0000 and 00000) catgut . . . a comprehensive group of sutures armed with swaged-on Atraumatic needles and designed for specific surgical procedures . . . Dermalon skin and tension sutures (processed from nylon) which, because of marked physical advantages and economy, are rapidly replacing silk worm gut and other non absorbable materials."

Booth 52

ELI LILLY AND COMPANY

Indianapolis, Indiana

"The Eli Lilly exhibit is evidence of the interest of Eli Lilly and Company in The Kansas Medical Society. Lilly products both old and new will be on display and Lilly representatives will be present to serve physicians in every possible way."

TECHNICAL EXHIBITORS EIGHTY-THIRD ANNUAL SESSION

1. Mead Johnson & Company, Evansville, Indiana.
2. Philip Morris & Company, Ltd., New York, New York.
3. The Borden Company, New York, New York.
4. The W. E. Isle Company, Kansas City, Missouri.
6. American Optical Company, Kansas City, Missouri.
7. The Mennen Company Newark, New Jersey.
9. Abbott Laboratories, North Chicago, Illinois.
10. The Mid-West Surgical Supply Company, Inc., Wichita, Kansas.
11. Holland-Rantos Company, Inc., New York, New York.
14. Smith, Kline & French Laboratories, Philadelphia, Pennsylvania.
15. Parke, Davis & Company, Detroit, Michigan.
17. and 18. Pet Milk Sales Corporation, St. Louis Missouri.
19. The Medical Protective Company, Fort Wayne, Indiana.
20. S. H. Camp & Company, Jackson, Michigan.
21. Greb X-Ray Company, Kansas City, Missouri.
23. Cerophyl Laboratories, Inc., Kansas City, Missouri.
24. H. G. Fischer & Company, Chicago, Illinois.
25. M. & R. Dietetic Laboratories, Inc., Columbus, Ohio.
26. Gerber Products Company, Fremont, Michigan.
27. Petrogalar Laboratories, Inc., Chicago, Illinois.
28. Burroughs Wellcome & Company (U.S.A.), Inc., New York, New York.
30. C. B. Fleet Company, Inc., St. Louis, Missouri.
31. E. R. Squibb & Sons, New York, New York.
32. General Electric X-Ray Corporation, Kansas City, Missouri.
33. A. J. Griner Company, Kansas City, Missouri.
34. William S. Merrell Company, Cincinnati, Ohio.
35. Dairy Council of Wichita, Wichita, Kansas.
37. American Hospital Supply Corporation, Chicago-New York.
39. Quinton-Duffens Optical Company, Topeka, Kansas.
40. and 41. Camel Cigarettes, New York, New York.
42. Ortho Products, Inc., Linden, New Jersey.
43. Archer-Taylor Drug Company, Wichita, Kansas.
45. Riggs Optical Company, Kansas City, Missouri.
46. A. S. Aloe Company, St. Louis, Missouri.
47. John Wyeth & Brothers, Inc., Philadelphia, Pennsylvania.
48. Carnes Artificial Limb Corporation, Kansas City, Missouri.
49. J. R. Siebrandt Manufacturing Company, Kansas City, Missouri.
51. Davis & Geck, Inc., Brooklyn, New York.
52. Eli Lilly & Company, Indianapolis, Indiana.

HOTEL RATES

	<i>Single</i>	<i>Double</i>	<i>Twin Beds</i>
ALLIS Broadway and William	\$3.00 to 4.50	\$5.00 to 6.50	\$5.00 to 7.00
LASSEN First and Market	\$2.50 to 5.00	\$3.50 up	\$5.00 up
	\$2.00 (without bath)		
BROADVIEW Douglas and Waco	\$2.50 to 3.50	\$3.50	\$4.00 up
McCLELLAN 201 S. Broadway	\$2.00 & 2.50	\$3.00 & 3.50	\$4.00
COMMODORE (Apr. Hotel) 222 E. Elm	\$2.75 to 3.50	Add \$.50	Add \$1.00

GOLF AND SKEET BANQUET

MONDAY, MAY 11, 6:30 P.M.

Crestview Country Club

As usual only two things are certain, the starting time and the place where the banquet will be held. Upon the close of the athletic activities at 6:30 P. M. at the Crestview Country Club, 4400 East Twenty-first Street, we will celebrate victory and attempt to assuage bitter defeat in the course of an informal dinner and a something less than scientific program. The day's plunder will be divided among the victorious on links and range and consolation shall be offered the remaining of us. The time for closing will be left to circumstances which you may determine for yourself.

ANNUAL BANQUET AND DANCE

WEDNESDAY, MAY 13, 7:00 P. M.

Blue Moon

Viewing this program from its scientific angle or its social aspects, or from its meal and the attractive surroundings, we believe you will agree that this is the high moment of the Annual Session. Frank H. Lahey, M.D., president of the American Medical Association, will be the speaker. Ted Fio Rito and his famous orchestra will play for the dance that follows. On this night the Blue Moon will be closed to all except our members, their wives and guests. Please note the announcement in the center pages of the Journal and obtain your tickets at the time of registration.

"CUM LAUDE" BANQUET

TUESDAY, MAY 12, 7:00 P. M.

Roof Garden, Broadview Hotel

The title is deceiving, but the occasion remains the same—an evening of good fun, excellent food on the Broadview Hotel Roof Garden at 7:00 P. M. Tuesday, May 12. An interlude of strictly non-scientific entertainment to commemorate heretofore unrecognized and unrewarded gentlemen of the Society who will receive their medical "Oscars." Come meet your colleagues and enjoy the fellowship of these "men who came to dinner" and see them prove that they "can take it with them." The tickets for refreshments, dinner, and "award ceremony" are \$1.50. Buy them when you register.

GOLF AND TRAP TOURNAMENTS

This year the Annual Golf Tournament will be held at the Crestview Country Club, 4400 East Twenty-first Street, and the Annual Trap and Skeet Shoot will be held at the Wichita Gun Club, three miles west on the Cannonball Highway. Both events will be held on Monday, May 11. Practice rounds for golf will begin about 10:00 A. M. and flights at 1:00 P. M. Players must declare themselves at the first tee for the round to apply on tournament play. Plans have been made for a full days shoot for the trap and skeet enthusiasts.

Winners of last year's rotating trap and skeet trophies, won in Topeka, will please notify Dr. G. B. Morrison at once, in order that a complete list may be made up for this year's shoot.

Prizes will be awarded, to winners of the events, at the Annual Golf and Trap Banquet to be held at 6:30 P. M. at the Crestview Country Club. Tickets may be purchased at the time of the tournament play or at the club house.



QUINTON-DUFFENS GOLF
TROPHY



MEAD JOHNSON GOLF TROPHY



MEAD JOHNSON TRAP
SHOOTING TROPHY

KANSAS MEDICAL ASSISTANTS' SOCIETY

Allis Hotel

MONDAY, MAY 11

- 8:00 A. M. REGISTRATION
Lounge, Allis Hotel
- 9:00 A. M. ADDRESS OF WELCOME AND RESPONSE
Reports of Councilors
- 10:00 A. M. SAFE-GUARDING THE PHYSICIAN'S PRACTICE
J. E. McCurdy, General Agent, The Medical Protective Company, Topeka, Kansas
- 10:20 A. M. THE PREPARATION OF WORKMEN'S COMPENSATION INSURANCE FORMS
Miss Opal Nichols, Secretary to Erskine Wyman, Workmen's Compensation Commissioner, Topeka, Kansas
- 10:40 A. M. WHAT ABOUT THE "DOCTOR-BILL"?
Melvin E. Clark, Credit Manager, The Geo. Innes Co. and President, The Wichita Retail Credit Association, Wichita, Kansas
- 11:00 A. M. CURRENT MEDICAL PROBLEMS
Clarence G. Munns, Executive Secretary, The Kansas Medical Society Topeka, Kansas
- 11:20 A. M. THE BIG BUSINESS OF UNSCIENTIFIC MEDICINE
Oliver E. Ebel, Executive Secretary, The Sedgwick County Medical Society, Wichita, Kansas
- 12:00 Noon LUNCHEON
Speaker: Mrs. Birdell M. Roseberry, Executive Secretary, American Red Cross, Sedgwick County Chapter, Wichita, Kansas
- 2:00 P. M. MEDICAL PREPAREDNESS
Forrest L. Loveland, M.D., Chairman, Kansas Committee on Procurement and Assignment, Topeka, Kansas
- 2:30 P. M. THINKING FOR VICTORY
Miss Evelyn Hunter, Counselor, Wichita Public Schools, Wichita, Kansas
- 3:00 P. M. BUSINESS MEETING AND ELECTION

General Information

Registration fee—\$2.00 (including luncheon Monday noon).

Sunday, May 10—Pre-convention registration, 2:00 P. M. to 5:00 P. M. Allis Hotel.

Beginning at 2:00 P. M. Sunday, the girls of the Sedgwick County Medical Assistants Society will hold open house in the Hostess Room, Allis Hotel, and arrangements have been made for sight-seeing and varied entertainment of delegates during the afternoon and evening.

President's Page

To the Members of The Kansas Medical Society:

As our Society year is closing it is my desire to take this opportunity to express my sincere appreciation for the wholehearted cooperation of the members of The Kansas Medical Society in its effort to maintain a high standard of medical practice in our State. Without the coordinated effort and cooperation you have shown throughout the year, the wheels of progress in organized medicine in our State would have moved all too slowly. Things have been accomplished throughout the year and others are in process of accomplishment.

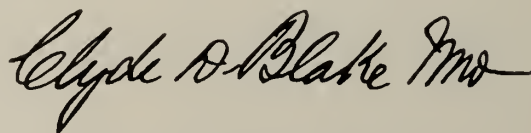
Not the least has been the continued upbuilding of public opinion brought about by the untiring efforts of committees in their educational programs throughout the year. Also, let us remember their valuable contacts with lay group in an effort to obtain adequate medical care for all the citizens of our State. Our Society through its committees has always responded and in joint action through the medium of advice and clarification, endeavored to assist in such efforts wherein the public and medical practitioners were concerned. While there is much yet to be done in the field of physician-public relationship, as pertains to medical service, it is felt that real and lasting progress has been made, and the fruits of this year's efforts through further endeavor in years to come will be realized in the not far distant future.

Time and space will not permit me to enumerate the numerous activities of the many committees of your Society throughout the year, or indulge in detail as to the numerous subjects discussed and acted upon in individual committee meetings as interesting and all inclusive as they were. Even their individual reports as published in the Journal and read in abstract at the annual meeting cannot convey in full the sacrifice in time and effort of the personnel of the numerous committee groups of our Society.

May your outgoing President at this time express to the members, officers, and committees, my heartfelt appreciation and admiration for your wonderful cooperation and laborious work throughout the year. My associations with you throughout has been most pleasurable.

And to you, Dr. Tihen, as our incoming president, let me assure you the members of The Kansas Medical Society will astound you in their willingness to serve.

Sincerely yours,

A handwritten signature in cursive script that reads "Clyde D. Blake M.D." The signature is fluid and elegant, with the initials "C.D." and "M.D." clearly visible.

President, The Kansas Medical Society.

EDITORIAL

THE RETIRING PRESIDENT

Dr. Clyde D. Blake of Hays has earned the gratitude of every physician in the State for his very capable service as President of the Society during the past year. His year was a particularly difficult one which included not only the usual responsibilities and duties incidental to that position but as well the important task of making preparations for the Kansas medical profession to provide its assistance to the country in the time of war. His record of accomplishments in regard to the medical preparedness program would in itself have made his year a successful one and it is noteworthy indeed that he was able to carry on and further the other programs of the Society in addition thereto.

Those who worked with him know that he gave almost his full time to the interests of the organization during his presidency; that he took part in numerous conferences, committee meetings, and discussions of medical interest; that he accepted all medical society and other invitations to talk which he received; that he traveled extensively in behalf of Society matters; and that he maintained close personal relationships with all allied organizations and agencies interested in public health and medicine. On many occasions during the year he attended three, four, or five meetings in various parts of the State during a week. A call from the central office advising of a new problem would immediately bring a reply that he would be in Topeka the next morning for discussion of the matter. His correspondence was voluminous and his other activities were similarly extensive. To a large extent he gave up the practice of medicine and a sizeable portion of his time with his family in service and assistance to his profession.

The following recital of the record of accomplishments during the past year shows clearly that the Society has made great progress under the leadership

of Dr. Blake, and that the confidence imposed in him by the House of Delegates, when it elected him to the presidency, has been more than fulfilled.

Arrangements were made so the Kansas profession will provide its share of physicians for the military forces and at the same time to the fullest extent possible provide for the needs of its communities. Committees were appointed and plans were adopted for that purpose, whose worth will become even more important as the present emergency develops. The results made possible in that connection are perhaps illustrated in the fact that Kansas today stands as one of the states which has given the greatest number of physicians per population to the military forces and that such has been done without serious interference



CLYDE D. BLAKE, M.D.

to civilian needs. Industrial and medical educational needs have also been met in a similar manner. The Kansas profession has continued its assistance in the medical aspects of the Selective Service program and it takes pride that these efforts have been praised by the National Selective Service Headquarters as among the best in the country. The county medical societies of the State have also developed efficient programs in conjunction with the National Civilian Defense Program. It can be said that sound and practical plans have been completed for Kansas physicians to provide their part in the winning of the war and that the Kansas profession stands ready and able to meet all development and eventualities toward that end.

Further progress was also made during the year on the subject of indigent medical care. Through excellent interest and assistance provided by the Kansas State Board of Social Welfare, an additional number of counties have adopted free choice plans for that purpose to the place that approximately eighty Kansas counties are now caring for the medical needs of the poor in that manner.

The illegal practice of medicine and surgery has continued as a major problem. However, through the advent of several new court decisions and through additional activities in this field, additional progress was made toward obtaining a satisfactory solution of this matter.

State Board of Health in numerous programs pertaining to improvement of public health and extension of medical services.

Nutrition, a problem of particular medical interest, received much lay attention during the year. Governor Payne H. Ratner announced the appointment of a Kansas Committee on Nutrition to work in conjunction with the National committee in the same field. The Society was extended representation on the State committee and is cooperating closely therein.

Postgraduate courses conducted during the year were as follows: The annual course on heart disease was held in Emporia; a tuberculosis course was held in Parsons, Wichita and Salina; the Kansas Obstetrical and Gynecological Society sponsored a series of meetings in various districts; and a course on industrial medicine was presented in Wichita.

A new Committee on Legal Medicine, composed of joint representatives of the Kansas State Bar Association and the Society, became active during the year. The Committee has made numerous plans pertaining to legal medical relationships and to medical jurisprudence which will be of particular assistance.

The Society accepted membership on the Kansas State Land Use Planning Committee, an organization composed of representatives of prominent farm organizations. Plans were made therein for consideration of farm medical problems and extension of farm medical services.

The Committee on Allied Groups engaged in study of a considerable number of matters pertaining to relationships with inter-professional groups and prepared future plans on these subjects. The Committee on Auxiliary assisted materially in the furtherance of the Kansas Medical Auxiliary program. The Defense Board aided in many ways in the handling of malpractice problems. The Committee on Control of Cancer continued to participate in numerous programs on that subject. The Committee on Constitution and Rules completed its revision of the Society Constitution and By-Laws and issued a pamphlet thereon to the membership. The Committee on Endowment cooperated with the Endowment Association of the University of Kansas

in the preparation of plans for the extension of endowment for medical research. The Committee on the Conservation of Eyesight assisted the Kansas State Board of Social Welfare in the conduct of its blind program and participated in numerous other programs for the improvement of vision. The Committee on the Study of Heart Disease presented its annual postgraduate program on that subject and cooperated with the Kansas State Board of Health and other agencies toward obtaining a reduction in heart disease morbidity and mortality. The Committee on Hospital Survey assisted the Kansas State Hospital Association in the institution of its group hospitalization program and prepared studies and other recommendations on other hospital matters. The Committee on Maternal Welfare took part in the presentation of postgraduate courses

on that subject and participated in various other programs for betterment of maternal welfare. The Committee on Medical Economics was active in studies of indigent medical care, medical service plans, farm-medical service and numerous similar matters. The Committee on Medical History commenced activity toward the preparation of a medical history of Kansas. The Committee on Pharmacy continued to function in a liaison capacity with the Kansas State Pharmaceutical Association. The Committee on Public Health and Education aided the Kansas State Board of Health in the operation of its new department on public health education. The Committee on Schools of Medicine assisted in numerous programs

PROCUREMENT AND ASSIGNMENT SERVICE QUESTIONNAIRE

Each physician in the State has received, or will receive within the near future, a questionnaire from the Procurement and Assignment Service in Washington.

The questionnaire is of great importance. The military forces have immediate need for a large number of physician volunteers. There is, also, particular need to have information concerning other places wherein physicians can serve their country during the emergency.

The Procurement and Assignment Service, therefore, requests that each physician in the country, regardless of age, physical condition, or type of practice, fill out and return his copy of the questionnaire immediately.

for the provision of assistance to the University of Kansas School of Medicine. The Committee on Scientific Work aided in various ways in furthering the interest of the Kansas profession on that subject. The Committee on Stormont Medical Library added approximately sixty new medical books to that library. The Committee on Locations studied the needs for additional physicians in the State and helped many communities in finding needed physicians. The Committee on Child Welfare continued its comprehensive program on that subject. The Committee on Control of Tuberculosis prepared recommendations concerning the need for additional sanatoria facilities in the State and was active in many other programs

for the reduction of the incidence and effects of that disease. The Committee on the Control of Venereal Disease provided further assistance in the Kansas venereal disease problem.

It is probably true that Dr. Blake is very happy that his year as President is now almost completed. The work and responsibilities incidental to the presidency of the Society have grown to a place that the job is a very difficult one and one of great self sacrifice. It is definitely true, though, that Dr. Blake can hand his gavel to his successor in office with the full realization that he has enrolled his name on the list of truly great Presidents of the organization. The Society compliments him and expresses to him its appreciation for a job well done.

PRESIDENT-ELECT

The Kansas Medical profession welcomes Dr. Henry N. Tihen of Wichita as its new President for the next year.

Dr. Tihen was born in 1896. He obtained his degree of doctor of medicine from the Rush Medical College of the University of Chicago in 1919 and was licensed to practice in Kansas in 1921. In addition to his membership in the American Medical Association, the Society and the Sedgwick County Medical Society, he is also a diplomate of the American Board of Internal Medicine, a fellow of the American College of Physicians and a member of numerous other organizations.

President Tihen is closely familiar with the work of the organization. He has served the Society as its President-Elect during the past year, as a Councilor for two terms, as a member of the Executive Secretary Committee which established its full time office, as Chairman of its Committee on Control of Tuberculosis, and in numerous other assignments and capacities.

It is probably true that the various matters incidental to the war, and the assistance the Kansas profession will need to provide will cause this year as President to be filled with many new questions, many decisions of magnitude, and many other prob-

lems. It is equally true, though, that Dr. Tihen's experience in the work of the Society, his excellent ability as a physician, and his general capabilities, will fit him to accept the important responsibility of his office.

The Society could not have chosen a better member to provide leadership during the all important year of 1942-43, and it pledges to Dr. Tihen its utmost assistance and cooperation.

EIGHTY-THIRD ANNUAL SESSION

The Sedgwick County Medical Society invites all members to attend the eighty-third annual session of the Society which is to be held at the Wichita Forum on Tuesday, Wednesday and Thursday, May 12th, 13th and 14th.

The scientific program will include excellent speakers in all fields of medicine and surgery. Likewise, particular effort has been made to choose speakers and subjects of interest to both the general practitioner and the specialist. The scientific and technical exhibits will be among the largest and most complete in the history of the Society. The Round Table luncheons, the section meetings, the entertainment events and all other arrangements incidental to a successful medical meeting have been provided.

The war has made it particularly difficult to complete plans for this year's meeting and the Sedgwick County Medical Society is to be congratulated for the excellent arrangements it has prepared despite that fact. Various matters resulting from the war will also make it difficult for many members to attend the meeting. It should, however, be remembered in the latter connection that physicians will be called upon during the emergency to engage in various forms of practice which they have not customarily handled and that they therefore owe to their country and their patients, the obligation of keeping up to date on all that is new and all that is old in medical practice. There is no better means in the State for that purpose than to attend the annual sessions of the Society.



HENRY N. TIHEN, M.D.

Hence, as a part of your contribution to medical preparedness — plan to attend the Wichita annual session.

We salute those members who are serving in the military forces and who therefore cannot be in attendance at the 83rd Annual Session.

OFFICIAL PROCEEDINGS

FOREWORD TO DELEGATES

Since the agenda of the House of Delegates has increased appreciably during recent years, an attempt will again be made to save the time required for the reading of reports by publishing in the Journal as many of these as possible.

All of the following reports will be discussed and presented for adoption but since they will not be read all delegates are requested to become familiar with them in advance of the meeting.

The following is the report of the Councilor of the First District:

TO: THE HOUSE OF DELEGATES:

Medical problems in this district have been few due to the fine cooperation of the county societies.

There are seventy-six active physicians in this district and sixty-nine are members. There is one active auxiliary. One district scientific medical meeting was held. Many societies meet once a month. Progressive medical service is being offered.

Respectively submitted,

J. W. Randell, M.D.,
Councilor, First District.

The following is the report of the Councilor of the Second District:

TO: THE HOUSE OF DELEGATES:

There is very little of specific interest to report for the Second District. A few minor problems that arose were dealt with as conditions seemed to warrant. Plans to hold a joint meeting early this year, in the district were dropped in difference to tire shortage and every ones interest is in the defense program.

Respectively submitted,

O. W. Davidson, M.D.,
Councilor, Second District.

The following is the report of the Councilor of the Third District:

TO: THE HOUSE OF DELEGATES:

It has been my privilege to serve as Councilor for the Southeast Kansas District for a number of years, in

which time we have not had any difficulty among our members. I wish to thank them for the opportunity of serving.

Respectively submitted,

L. D. Johnson, M.D.,
Councilor, Third District.

The following is the report of the Councilor of the Seventh District:

TO: THE HOUSE OF DELEGATES:

Cloud county reports a number of meetings, good membership, and the immunization of 457 children against diphtheria in the past year.

Republic county reports that they have had meetings each month throughout the year and that they have sponsored a diphtheria immunization program as well as a program for tuberculosis testing of school children.

Washington county reports an excellent membership and monthly meetings throughout the year. At one of their meetings they entertained the Washington County Press Club.

Mitchell county reports that they held five meetings throughout the year, and sponsored a program for tuberculosis testing of all school children, also a program for immunization of children under ten years of age, for diphtheria.

Jewell county reports the loss by death of their President, Dr. J. E. Hawley and also their health officer, Dr. S. B. Dykes. They are entering their third year with the Farm Security Administration.

Clay county reports regular monthly meetings, excellent membership, a tuberculosis testing program for all school children in the second and eleventh grades, immunization of 657 school and pre-school children for diphtheria.

Riley county reports regular monthly meetings and five special meetings, five new members and one transfer were admitted to membership. A venereal disease clinic was established. Tuberculin testing of Kansas State College employees was performed by members of the Society.

All local medical societies report excellent cooperation from their members on the government work of examination of men under the Selective Service Act.

Respectively submitted,

F. R. Croson, M.D.,
Councilor, Seventh District.

The following is the report of the Councilor of the Eighth District:

TO: THE HOUSE OF DELEGATES:

In concluding my tenure of office as Councilor of the Eighth District of The Kansas Medical Society, I wish to commend the fine spirit of cooperation I have found among the individuals of this district whom I have asked at various times for help, and to assure my successor of the continuation of this fine trait. Then I should like to say that, in serving as Councilor, I have gained much more than I have given in experience and knowledge of the complexities of this organization of ours. I am both conscious of and grateful for the

patience you have shown at times when I knew it was difficult for you to be patient. For these and other kindnesses, I wish to express my sincere appreciation.

For the men remaining in the Council and the newer men who will soon enter, I anticipate a rich experience and, as I return to my place as an ordinary member, I am completely confident that our affairs are in safe hands. May we all remember that their work will be made easier and our organization better when constructive ideas are presented rather than sharp criticism, though the latter seems easier material for verbiage.

My hope is that the next six years will see our Society continue to grow in cooperative spirit among its members, in the strength of its scientific program, and in its wise social influence.

Respectively submitted,

L. S. Nelson, M.D.,
Councilor, Eighth District.

The following is the report of the Councilor of the Ninth District:

TO: THE HOUSE OF DELEGATES:

I am very glad to state that all physicians of this district have given full support during the past year. There are not too many doctors in the district, but I believe that the people are being adequately served when sick.

Every man expresses his desire to serve the war effort where ever he is needed most.

The Colby men are very proud of a new hospital, a fine addition to medical service in this district.

There was more interest in the cancer program this year.

Respectively submitted,
Haddon Peck, M.D.,
Councilor, Ninth District.

The following is the report of the Councilor of the Eleventh District:

TO: THE HOUSE OF DELEGATES:

The Eleventh Councilor District is so scattered over the area out here and is so sparsely settled that it is hard to make annual visits to all of the counties. In view of this it was thought advisable to organize a district council society to meet three or four times a year.

On February 26, a meeting was called for Kinsley at which time the Eleventh Councilor Society was organized with the intention of having at least three meetings during the year besides the meeting at the time of the State Society.

Officers elected at that time were: President, Herbert Atkins, M.D., of Pratt; Vice-President, L. A. Lattimer, M.D., of Alexander; Secretary-Treasurer, F. E. Dargatz, M.D., of Kinsley. G. O. Speirs, M.D., of Spearville, Councilor of the Twelfth District was present at the meeting.

Some much needed business was transacted at this meeting. The district generally is in good condition. We are hoping to get some action in regard to the illegal practice of medicine and surgery.

There has been several meetings of the Council held at Topeka, where business of the Society has been attended to in a workman like manner.

Respectively submitted,

Herbert Atkins, M.D.,
Councilor, Eleventh District.

The following is the report of the Councilor of the Twelfth District:

TO: THE HOUSE OF DELEGATES:

The past year has brought a touch of prosperity to this district. Supplementing last years good crops, green wheat fields with numerous fattening cattle and sheep, have replaced the "dust bowl" and increased the income tax of all, doctors included.

Four of our boys are in the Army. Drs. G. K. Lewis and H. C. Sartorius of Garden City; Dr. R. E. Speirs of Dodge City and Dr. D. J. Wilson of Tribune.

The Ford County Medical Society, the only active society in the district, has had many good meetings during the past year with good attendance. A new society, the Clark County Medical Society, is in the progress of organization.

The Farm Security Medical Plan as informally considered in our district meeting seemed hopelessly downed but a secret mail ballot brought a vote of seventy-five per cent favoring it. It will be continued another year.

Three county seat towns in good communities are without physicians. As a result our hospitals are better filled but the former readier access to medical service is crippled.

Aside from the men who have been called to the Army, a few changes have occurred. No deaths within the year. Dr. E. M. Ireland, formerly of Coates, has transferred to Lakin. Dr. G. R. Hastings, formerly of Lakin has gone to Garden City, as has Dr. E. R. Beiderwell, formerly of Belleville. Dr. George Mandeville, formerly of the Halstead Clinic, has located in Dodge City.

Correspondence from any well qualified physician desiring a location will be welcomed.

Respectively submitted,

G. O. Speirs, M.D.,
Councilor, Twelfth District.

SELECTIVE SERVICE REHABILITATION PROGRAM

The National Selective Service System is completing plans to institute a program for provision of rehabilitation medical and dental treatment to certain rejected Selective Service registrants.

Registrants whose present disabilities are certified by induction boards as being remediable will be authorized to receive medical and dental assistance, at government expense, from private practitioners of medicine and dentistry.

Kansas doctors of medicine who desire to participate in this program should write the State Director, Kansas Selective Service, Topeka, requesting application forms. Complete application forms will then be forwarded by the Kansas Selective Service to Washington for approval. Physicians whose applications are approved will be listed as eligible to provide services under the program.

The following is the report submitted by H. M.

Glover, M.D., Chairman of the Committee on Automobile Accidents and Fractures:

TO: THE HOUSE OF DELEGATES:

Your Committee on Automobile Accidents and Fractures wishes to report a very active and interesting year of study of problems involved. A meeting of this Committee was held in Newton, on September 28, at 2:30 p.m. Those present were: Dr. H. M. Glover, Chairman, Dr. W. H. McKean, Dr. H. E. Snyder, Dr. C. B. Trees, and Dr. C. H. Johnson, also present was Dr. Clyde D. Blake, President of the Society, Dr. J. L. Grove, Councilor of the Fifth District, Dr. J. A. Wheeler, and Clarence G. Munns, Executive Secretary of the Society.

The matters to be handled by this Committee were grouped and discussed under the following headings:

1. The provision of liaison assistance to the Kansas Safety Council, the Kansas Highway Commission, and the Kansas Highway Patrol in the medical aspects of the prevention of automobile accidents and in the care of automobile accident victims.

2. Study of lien laws, arrangements with insurance companies, the Kansas Financial Responsibility Law, and other means wherein physicians in hospitals can be assisted in receiving compensation for the care of automobile accident victims.

3. Study of the physical examination requirements made of the drivers license laws of other states.

4. Study of tests to determine alcoholic intoxication and preparation of a report on this subject for the Kansas Highway Patrol.

5. Investigation of possibilities for obtaining specially designated automobile licenses for Kansas doctors of medicine.

6. Preparation of the Kansas fracture program.

7. Study and report on the medical aspect of the prevention of automobile accidents particularly in regard to vision and eradication of highway hazards which interfere with proper vision.

Your Chairman and members of this Committee have interviewed executive officers of all of the other organizations listed above who are interested in the prevention of highway accidents and some very valuable ideas have evolved from these discussions.

This Committee has arranged for a booth at the State Meeting of The Kansas Medical Society in the Forum, at Wichita, and is busy preparing an exhibit which we hope will be instructive and helpful in the department in which this Committee is most interested.

The following is the report submitted by C. Omer West, M.D., Chairman of the Advisory Committee to the Women's Auxiliary:

TO: THE HOUSE OF DELEGATES:

During the past year the Auxiliary to The Kansas Medical Society has shown marked progress. Their program has been varied and nearly every chairman has been active in her particular part of the program.

The Chairman on Legislation had a good program which she instituted to be followed among the auxiliaries of the State. In this program she asked that each county auxiliary give a brief report of legislation at every meeting and that every member become acquainted with the purpose and the need of all proposed laws.

Hygeia has been well distributed throughout the State.

There has been a furtherance in the activity of the public relations program. Its work has been varied and seems to cover the field most remarkably. Through the efforts of this Chairman, a study of nutrition has been made; speakers for lay health programs have been obtained, (Dr. W. W. Bauer from the American Medical Association central office was brought to the State for a series of lectures.) There has been instituted and carried forward a very wide and diversified program on national defense. Members who are qualified have been encouraged to aid the Red Cross work by teaching first aid, emergency nursing and dietetics. All in all, this part of the program of the Auxiliary is the most encouraging.

Closer contact has been made among the members by the very active Press and Publicity Chairman. Through her work, members are becoming better acquainted and better work can be expected in the future through this acquaintanceship.

Some new plans have been started for extension of the organization over the State. An attempt is being made to encourage the various Councilors to organize their districts. There has been some loss of membership but this is to be expected due to the number of active members' husbands who have been inducted into active military service. There has been no loss of growth as a whole and the future looks bright.

The Auxiliary has had an especially fine year under the splendid organized leadership of Mrs. W. Y. Herrick of Wakeeney. The Auxiliary Advisory Committee feels that the efforts of the medical wives justifies more careful attention and more sympathy and encouragement from the physicians of Kansas.

The following is the report submitted by A. W. Fegty, M.D., Chairman of the Committee on Constitution and Rules:

TO: THE HOUSE OF DELEGATES:

No meeting of this Committee has been called during the past year for the reason that unavoidable delays prevented the printing and distribution of booklets containing the present Constitution and By-Laws and the Code of Ethics of the American Medical Association.

A few proposed amendments are almost ready to be presented to the Committee and if possible some of these may yet be presented for action at this session. Briefly the following subjects are to be considered:

1. Official inclusion in the By-Laws of the two reference committees which have functioned for the past two years on trial, in an effort to condense and present briefly to the House of Delegates only the vital and important points in the various reports of committees and officers.

2. Formation of a nominating committee.

3. Limiting committee service to three consecutive years.

4. Limiting American Medical Association Delegates to three consecutive terms of two years each.

5. Provision for associate membership.

6. Limit defense assistance to correspond to those cases protected by insuring companies.

7. Limit wording of defense assistance on application of member to —"Assist in all ways possible in

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Brückner, H—*Die Biochemie des Tabaks*, 1936

***The Military Surgeon*, Vol. 89, No. 1,
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mal-practice cases." (Present wording intimates full charge of defense by attorney for Defense Board, which is satisfactory in all cases handled exclusively by the Defense Board, but should be modified to fit cases in which the defendant chooses to hire additional counsel, or those cases in which the defendant has full coverage from an insuring company but wishes to have the additional benefit of Society defense.)

8. Permit membership in county of non-residence for good and sufficient reasons of a varying nature WITH CONSENT of the society of residence.

It is the hope of the present chairman and his Committee that any and all changes suggested or made in the wording of our By-Laws shall have due consideration by officers and members, and any changes made shall be only to make it more ideal and provide a more successful working basis for the Society.

We regret that unavoidable delays have prevented any definite accomplishment by this Committee for the current year up to this date.

The following is the report submitted by George F. Gsell, M.D., Chairman of the Committee on Conservation of Eye Sight:

TO: THE HOUSE OF DELEGATES:

Your Committee on the Conservation of Eyesight wishes to report on its activity for the year ending May, 1942. The main activity of the Committee has been its continued function as official advisor to the Board of Social Welfare on matters concerning blindness and the prevention of blindness, which come under the jurisdiction of that board. In this connection it has worked in close harmony with the office of the State Consulting Ophthalmologist. Early in the year the Committee met with the State Board of Social Welfare in Topeka, consulting over various problems concerned with the administration of the Welfare Act.

The Committee considered the advisability of sponsoring post graduate courses over the State in eye, ear, nose and throat. After mature consideration it decided that such course in these specialties would not be of sufficient benefit to accomplish their purpose.

The Committee has concerned itself about some of the deficiencies of the Kansas Compensation Act as regards the evaluation of visual loss. It has considered the relatively new problem for Kansas of eye hazards in industry.

The following is the report submitted by Howard E. Snyder, M.D., Chairman of the Committee on Control of Cancer:

TO: THE HOUSE OF DELEGATES:

The Activities of the Committee on the Control of Cancer have been curtailed because of the war emergency. Nonetheless, a rather comprehensive program has been completed.

The finest possible cooperation has been received from the Kansas State Board of Health and a major part of the program has been possible only because of the fine cooperation of Dr. F. C. Beelman and all other members of the organization. The Board of Health printed fifty thousand copies of a pamphlet on cancer of the stomach for lay distribution. This pamphlet was most carefully worked out by the State

Board of Health. Scientific data for the pamphlet was prepared by the Committee on the Control of Cancer. The State Board of Health has also sent out at monthly intervals this year a cancer bulletin to all doctors in the State. This has been done through the cooperation with the Committee. The State Board of Health has also purchased literature in large quantities for distribution by the Women's Field Army and its component units. They have also made available the services of Mr. Ben Lowther of the Department of Visual Education for the entire month of April. During the month of April every district in the State is being covered by Mr. Lowther. Two to four meetings are being held daily at which time Mr. Lowther presents motion picture films on the subject of cancer for the lay meetings and the medical speaker is furnished by the local county medical society. The State Board of Health has also prepared posters for use in the April enlistment campaign of the Women's Field Army.

The Committee has also cooperated to the fullest extent with the Kansas Division of the Women's Field Army. The Committee has planned with the Women's Field Army a program of lay education stressing cancer of the stomach this year. Many programs have been held and many more will be held throughout the State. Again this year the county medical societies have been asked to furnish speakers for local meetings. In some instances these have been provided from their own membership, in other instances speakers from without the county have been asked to speak, in other instances the Committee on Control of Cancer has been asked to furnish the speaker. Cooperation of the county medical societies in this program has been much better than in previous years. Mrs. J. E. Johtz of Abilene, the new State commander, has been doing a very fine job in organizing and in coordinating the activities of the Kansas Division of the Women's Field Army.

In connection with the lay program on cancer of the stomach the Committee has prepared a speech on cancer of the stomach suitable for use by doctors speaking at lay meetings. This speech was printed in the Journal of The Kansas Medical Society and reprints of the speech have been distributed to the officers of all county medical societies. The loan packets on cancer have been revised and are available at all times.

A number of the exhibits in the Scientific Exhibit Section of The Kansas Medical Society meeting in Wichita will deal with the subject of cancer. One of these exhibits is the exhibit prepared by the Committee in cooperation with the State Board of Health for the American Medical Association meeting in Cleveland last year. Another exhibit is by Dr. Marion Trueheart of Sterling, a member of the Committee on Control of Cancer.

Because of the war emergency, it was found necessary to cancel the five-day post graduate course on cancer which has been planned for March of this year. It is also necessary to cancel the proposed program of post graduate cancer lectures before county medical societies throughout the State. One other feature planned which has not as yet been consummated because of the press of war activities is the bulletinizing of all the men's service clubs in the State asking them to present one program on cancer at some meeting during the next year. This may yet be done.

Due acknowledgement must be made of the fine cooperation and the many suggestions emanating from

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the Executive Secretary of The Kansas Medical Society. The cancer bulletins which have been distributed by the Kansas State Board of Health were developed from a suggestion by Mr. Munns. Many other valuable suggestions have been made by him and many valuable services have been rendered.

Your Committee feels that there should be no let down in the program of public education concerning cancer. Parts of the cancer control program will of necessity be curtailed because of the war, but much can yet be done despite the emergency.

The following is the report submitted by C. H. Lerrigo, M.D., Chairman of the Committee on Control of Tuberculosis:

TO: THE HOUSE OF DELEGATES:

The work of the Committee on Control of Tuberculosis for various reasons has been obliged to go along through the past year by correspondence. Dr. Omer M. Raines, chairman, had a call to Army service early in the year and is now in the service at Fitzsimmons Hospital, Denver. Dr. Raines gave particular attention to some of the problems before being called to the service and at least one big question has been settled through a correspondence vote of the members. The Tuberculosis Division of the State Board of Health with which this Committee always works in close cooperation was likewise upset by the fact that the head of that Division, Dr. F. C. Beelman, was called upon to assume full duties as executive officer of the Kansas State Board of Health. As of March 1, the new Director of the Division of Tuberculosis Control was obtained in the person of Dr. H. L. Hiebert, a Kansas boy who comes to the work after three years' experience in the State Sanatorium of Minnesota.

Your Committee on Control of Tuberculosis has now under consideration the special problems of increased incidence of tuberculosis in our Negro and Mexican populations; and the fact that some 120 Kansans are on the waiting list of Norton Sanatorium, has indicated that greater facilities must be offered to permit the admission of cases diagnosed as tuberculosis to sanatorium treatment while still in the minimal stage.

We are obliged to repeat from the report of last year that "adequate sanatorium facilities in southeastern Kansas are much needed." We are glad to add to this (also from the report of last year), that the recommendation of this Committee for special study by the Legislative Council through its research bureau has gone actively forward. In the year that is just closing, the Kansas State Tuberculosis Association has continued active work; and jointly with the Kansas State Board of Health, has introduced a feature of physical rehabilitation of men rejected by Selective Service Boards for "diseases of the lungs." This has done such good work that out of 570 rejectees, more than two-thirds have now received advice and counsel, all of which are included in reports made by the Kansas State Board of Health.

The following is the report submitted by L. S. Nelson, M.D., Chairman of the Defense Board:

TO: THE HOUSE OF DELEGATES:

Your Defense Board has answered each call upon it

to the best of its ability, and has rendered defense where it has found it constitutionally possible and where the member's own county society has approved the ethical advisability.

It is well for each member to bear in mind that he has a share in this plan which entails a two-fold responsibility. The first seems to the Defense Board to include a paid-up membership in The Kansas Medical Society which is essential, according to our constitution, for granting aid. The second, which is even greater, is the application of the golden rule in discussing illness or disabilities of disgruntled patients who have come from a colleague. It is these people who hunt for a lawyer who will encourage them to sue a physician for alleged malpractice. A watchful guard should be ever present with each man in his conduct, to see that he does as he would that others do unto him under similar circumstances.

There is a growing concern over defending members doing x-ray therapy and not belonging to a recognized radiological society nor carrying their own insurance elsewhere. The Council has not wanted to limit or reduce our defense program, but unless our members in this category, of which we think there are only a few, are not very careful, such limitation may become necessary.

Finally, the records of all the activities and expenditures of the Defense Board are open at all times to every member who wishes to familiarize himself more intimately with any portion of the work. Suggestions are always welcome.

The following is the report submitted by H. L. Chambers, M.D., Chairman of the Committee on Endowment:

TO: THE HOUSE OF DELEGATES:

The personnel of the Committee on Endowment is so widely scattered that I deemed it unkind to call the Committee together unless there was something definitely important to consider, and, therefore, the Committee was never all together at any one time or place during the year.

Part of us met in Independence with a representative of the University of Kansas Endowment Association and tried to plan a way to finance a medical science building for the campus at Lawrence. This matter is still in consideration and largely out of our hands, but is still in friendly hands. This representative and some of us also called on members of the profession in Neodesha and in Coffeyville and spread our propaganda on and in them.

We still strongly recommend that our members keep in mind the possibility of directing worthy use of funds through endowment associations.

We invite any one knowing of funds that are about to be left to relatively unimportant or less worthy employment to contact either some member of our Committee or the University of Kansas Endowment Association.

The following is the report submitted by A. R. Hatcher, M.D., Chairman of the Committee on Hospital Survey:

TO: THE HOUSE OF DELEGATES:

The main activities in regard to hospital work in

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this State during the past year have pertained to the group hospitalization program being sponsored by the Kansas State Hospital Association. The Association was successful in passing an enabling act at the 1941 session of the Legislature wherein a corporation could be organized for the sale of hospital insurance of this type to the general public. Since that time the Association has engaged in investigations of the type of program to be offered and it has also created committees and other arrangements toward that end. Progress has been made in this direction and the Association hopes to be able to announce its program in detail within the near future.

Two new hospitals were opened in the State during the year and plans were made for the institution of several others. The new hospitals consisted of one at Colby and another at Kinsley. Russell, Seneca and Herington are considering the construction of new hospitals.

A considerable number of hospitals in the State have constructed additions and improvements and have added new and needed equipment.

Defense activities have occasioned a hospital problem in certain areas of the State. Several of the hospitals in Wichita and Kansas City have filed applications under the Lanham Act, recently passed by Congress, for assistance in this regard.

Our Committee is attempting to cooperate with the Kansas State Hospital Association and all other agencies interested in hospitals to the fullest extent possible and will appreciate receiving all suggestions toward furtherance of that result. It will also be glad to attempt to help county medical societies or members in any way it can on hospital needs.

The following is the report submitted by L. F. Barney, M.D., Chairman of the Committee on History:

TO: THE HOUSE OF DELEGATES:

The foremost activity of the Society during the past year has been in connection with the war. The Society Committee on Medical Preparedness and the Kansas Committee on Procurement and Assignment Service have cooperated closely with the National Committee on Procurement and Assignment Service and with the American Medical Association in furnishing physicians for the military forces. Of particular interest in that regard is the effort being made by the government to supply military needs by and with consideration of civilian needs to the fullest extent possible. The program designed for this purpose has been excellently prepared and has worked most satisfactorily. Approximately 200 Kansas physicians have entered the military forces at the time this report was written. The State Society and the county societies have also been active in developing and organizing medical civilian defense plans and in numerous other programs wherein it is hoped the Kansas medical profession can assist in winning the war.

Other prominent activities of the Society during the past year were as follows:

Post-graduate courses were presented by the Committee on Heart Disease, the Committee on the Control of Tuberculosis, the Committee on Industrial Medicine and the Committee on Maternal Welfare in conjunction with the Kansas Obstetrical and Gynecological Society, on subjects pertaining to the work of those committees.

colological Society, on subjects pertaining to the work of those committees.

The Society became a member of the Kansas State Committee on Land Use which is an organization consisting of farmers and farm groups, and is assisting therein in activities pertaining to farm-medical questions.

Progress was made on the subject of indigent medical care during the year and a considerable number of additional counties adopted plans for this purpose offering free choice of physicians.

Further efforts were made to curtail the practice of medicine and surgery by illegal practitioners.

The Council of the Society voted to recommend to all members that mileage charges for service to farm families should be eliminated and that a method be substituted therefor wherein fees for farm medical calls would be based on actual automobile expense, time spent, and the individual services rendered.

A new Committee on Legal Medicine composed of joint members of the Kansas State Bar Association and The Kansas Medical Society was appointed to assist in the handling of legal-medical relationships.

Dr. F. C. Beelman was named as Secretary of the Kansas State Board of Health to replace Dr. F. P. Helm who resigned. Other new additions in the State Board of Health office were: Dr. Homer L. Hiebert, appointed as Director of the Division of Tuberculosis and Dr. Henry Asher, Director of Local Health Activities.

The need for birth certificates in connection with defense and other activities has continued to present a problem of magnitude for the Board of Health. The Board, however, has provided efficient organization on that subject and Kansas today stands as one of the leading states in this regard.

Several members of the Society were elected to national medical offices during the year: Dr. J. L. Lattimore of Topeka, has served as President-elect of the American Society of Clinical Pathology; Dr. Ernest Seydell of Wichita, as President of the American Otological Society; Dr. A. K. Owen of Topeka, as Councilor of the American College of Radiology for Kansas; Dr. W. M. Mills of Topeka, on the Executive Committee of the Western Surgical Association and Kansas Governor of the American College of Surgeons; Dr. C. E. Coburn of Kansas City, Kansas representative, Director of the National Tuberculosis Association; Dr. C. H. Lerrigo of Topeka, Advisory Committee, Conference of Child Health and Education of the National Tuberculosis Association; Dr. A. L. Ashmore of Wichita, Kansas Governor of the American College of Chest Physicians; Dr. C. C. Hawke of Winfield, Regional Director of North Central States American Association of Mental Deficiency; Dr. T. T. Holt of Wichita, Vice-President of the American College of Physicians; Dr. H. H. Jones of Winfield, Kansas representative, Board of Governors, American College of Physicians; Dr. Paul E. Belknap, President, Southwestern Pediatric Society; Dr. Karl A. Menninger, President of the American Psychoanalytic Society and Councilor of the American Psychiatric Association and Dr. William C. Menninger, Secretary of the Central Neuropsychiatric Association and Secretary of the American Psychiatric Association.

The Society membership for 1941-1942, was approximately 1500, which compares favorably with recent years. New county societies were organized in Chase and

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Morris counties.

The country is confronted with a very serious war. Many of our committees and other activities will need to be disrupted and changed, and many of our members will need to make great sacrifices in contributing to the victory which we must and shall have. It goes without saying though, that Kansas medicine stands ready and willing to do its utmost toward that end, and that it is equipped and organized to perform any services our country may desire.

The following is the report submitted by Charles Rombold, M.D., Chairman of the Committee on Industrial Medicine:

TO: THE HOUSE OF DELEGATES:

The Committee on Industrial Medicine on November 23, 1941, adopted the following program for 1942 and '43:

1. Revision and completion of the fee schedule of the Compensation Commission.
2. Publish in the Journal of The Kansas Medical Society an article by the Industrial Commissioner on Kansas Workmen's Compensation law.
3. A brochure to be published including the fee schedule, an abstract of the compensation law, suggestions on handling compensation cases, etc. That this brochure be sent each physician in the State.
4. Present a post-graduate course on evaluation of disability in compensation cases.
5. Prepare an exhibit on industrial medicine for the State meeting of The Kansas Medical Society.

The Committee on Industrial Medicine has accomplished the following to date:

1. Revision and completion of the fee schedule.
2. Mr. Erskine Wyman's article was published in the January, 1942, issue of the Journal.
3. The post-graduate course was held in Wichita on March 3.
4. The brochure will be published in the near future.
5. There is prepared an exhibit on industrial medicine for the annual State meeting.

The following is the report submitted by Robert H. Moore, M.D., Chairman of the Committee on Pharmacy:

TO: THE HOUSE OF DELEGATES:

Your Committee on Pharmacy has been very inactive this year, primarily, because of defense and war activities. This Committee has not had a meeting, however, Mr. Munns and I met with the committee from the Kansas Pharmaceutical Association on February 22, at the Jayhawk Hotel in Topeka.

There was nothing done at this meeting. It was more of a general discussion to attempt to establish closer cooperation between medicine and pharmacy.

This Committee will meet during the Wichita meeting.

The following is the report submitted by E. C. Duncan, M.D., and F. L. Loveland, M.D., Co-Chairmen of the Committee on Public Policy:

TO: THE HOUSE OF DELEGATES:

This Committee held a joint meeting with the

Council on February 22, wherein several important matters were considered.

Since 1942 is not a regular Legislative year, the Committee work during the year has consisted mainly of plans and preparations for the future.

The following is the report submitted by Fred J. McEwen, M.D., Chairman of the Committee on Medical Schools:

TO: THE HOUSE OF DELEGATES:

The Committee on Medical Schools held one meeting on October 8, 1941, at Kansas City, Kansas, at the School of Medicine of the University of Kansas. Almost the entire membership of the Committee was present, and in addition, Dr. C. D. Blake, President, Hays; Dr. O. O. Stoland, Professor of Physiology, Lawrence, and Mr. Clarence Munns, our State Executive Secretary, attended.

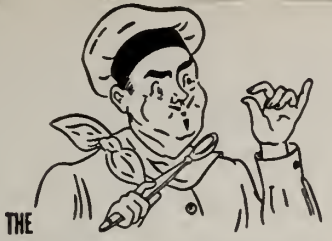
The Committee held its meeting in the morning, at which time various problems of the medical school and its relationship to the medical profession in Kansas were freely and openly discussed by the Committee and visitors. Some of the more important problems brought out in the discussion were as follows:

1. The Pre-Clinical Division of the medical school at Lawrence, continues to occupy scattered and makeshift quarters, as it has done in the past. The faculty hopes that when the new Industrial Building has been completed at Lawrence, that it will be possible for the medical school to move into the present Geology Building; however, the rate of construction and the arrival of materials will depend somewhat upon the war, and this may cause a considerable delay in relieving a trying situation at Lawrence for both the faculty and the students who are beginning to study medicine.

2. The library of the medical school has been receiving a considerable number of medical journals which the Editorial Board of The Kansas Medical Society receive on an exchange basis. The medical school has been carrying an advertisement in our State Journal informing the medical profession of the fact that the library service is available to the members of the profession, and that suitable material will be forwarded on a package basis for their use, if the request is made to the medical school. A large number of doctors have made use of this service during the past year.

3. The Committee expressed approval of the effort of the medical school in providing a fine post-graduate program during the past year, which has offered to the medical profession of the State of Kansas an opportunity for a splendid post-graduate course in many medical subjects during the Easter vacation. This year the University has abolished the Easter vacation, and it will be impossible for the medical school to offer this course at this time, however, it may be possible at a later date.

4. The Committee made an extensive tour of the hospital and medical school, the Hicks Memorial Library and Research Building, and the new out-patient clinic department, and are pleased to report to the House of Delegates that the medical school is making steady and constant improvement. The buildings and grounds now represent an investment of some \$2,500,000, and there are plans for still further enlarge-



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ment and improvement. The new Negro wards are very fine, and are now fire-proof, and the old temporary barrack-like structures have been torn down.

Every physician in Kansas should plan to pay a visit to the Kansas City division of the medical school and see just what has been accomplished, and the Committee feels that it will be a pleasant surprise and a source of considerable pride among the men of the profession of this State in the accomplishments of the school and its faculty who have made this progress possible. The Committee feels that Dean Wahl and the entire membership of the faculty and the hospital staff are to be commended for their fine work in building and maintaining a really fine medical school in the State of Kansas.

5. The problem of admission continues to be a troublesome one and is being capably handled at this time by a faculty committee, which interviews personally every candidate who fulfills the requirements for a successful application, after such requirement as; good character, good health, and required subjects have been satisfactorily attained. The final success of the candidate must depend to a certain extent upon his scholarship. The University is supported by the taxpayers of Kansas, and other things being taken into consideration and being equal, the final approval of the Committee must depend on the scholarship of the applicant. If there are more applicants than can be accommodated, only those with the highest grades can be accepted on any fair basis of appraisal. It would be wise, therefore, for the physicians of Kansas who have relatives or friends who plan to enter the medical school to be aware of the requirements for entrance; it would also be very wise to inform these young men and young women who plan to enter the medical school that they should try to have grades of a "B" average during their college years. It might even be well if they had a little better than a "B" average at this time. The Committee feels that if the physicians of the State are aware of these requirements, it will be possible to prepare the proposed applicant several years in advance so that they will not be eliminated because of poor grades during the college years.

Dean Wahl has prepared a resume of the present status of the medical school in regard to students and the different classes and activities of the medical school with regard to military service, and the plans of the school for a new Student Union Building to be built at Kansas City on a subscription basis from alumni and friends. His report follows the report of the committee.

The following is submitted by Dean H. R. Wahl of the University of Kansas School of Medicine, at Kansas City, as referred to in the above report:

TO: THE HOUSE OF DELEGATES:

The post-graduate clinics which were always given in the past during the Easter vacation were eliminated because of the national emergency which necessitated changes in the University calendar abolishing the Easter vacation. We are hoping that these clinics can be renewed later in the summer between the closing of the summer session and the opening of the fall semester.

Medical school this year increased its admission requirements to an average grade of 1.3. This was proposed in the catalog a year ago but is taking effect

with the freshman class entering in 1941. This has been an aid in overcoming a large number of applications which seem to have increased instead of decreased since the national emergency began.

The following statistics are of general information regarding medical school:

Total number of students now enrolled.....	336
Number of Freshman students (Regular).....	63
Number of Freshman students (Summer Quarter) ..	20
Making a total of Freshmen enrolled.....	83
Number of Students enrolled in the Kansas City, Kansas division	253
Number of Senior Students (Regular).....	70
Fourth Quarter or Summer Session Students.....	12
Regular Junior Students.....	70
Fourth Quarter Junior Students.....	12
Regular Sophomore Students.....	70
Fourth Quarter Sophomore Students.....	18

The fourth quarter students are those who were not able to get into many of the classes during the regular year because of limited facilities but make up these during summer classes when there are more facilities available.

The total number of student applications received from residents of Kansas was 109. Of these eighty-six were admitted. In the summer fourteen were placed on the waiting list and ten did not enter the medical school after they were accepted. Twelve Kansas applicants were not eligible for admission. Only two Kansas applicants who were fully qualified were not admitted. The total number of applicants was 214. This does not include all of the applicants coming from the Eastern states of whom there were several hundred but no attempt was made to list them. Seventeen applications were received from Kansas City, Missouri and of these six were admitted. Of the Kansas residents fifty-eight were admitted in the regular class and nineteen were admitted in the summer quarter group. There are ninety-three nurses in the Nurses Training School. Thirty-six members were in the graduating class last June. Of the student nurses fifty-two are enrolled in the combined college and Nursing School and forty-eight for one or more years of college work. The Nursing School now requires one year of college for admission into its training course.

The medical school is making arrangement for construction of a Student Union Building and dormitories. The Board of Directors for this new organization were recently organized and are laying plans for the building and for the raising of funds for the construction of same. It is hoped that through alumni contribution, faculty contributions, and those from the student body, sufficient funds can be raised to erect a badly needed Union Building which will provide additional space for holding clinics in post-graduate instruction. It is not expected to begin the construction of such a building during the national emergency but it is hoped to have plans and funds all available as soon as this emergency is over.

Medical school is making every effort to conform to the general military movement and increase and provide the maximum output of physicians and nurses and extra nurses courses are to be opened in June. The summer months are to be utilized to the fullest extent thereby increasing the number of graduates each year. The main graduating class will complete its training in June while an additional class of from twelve to eighteen men will receive their degrees in September,

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thereby increasing the output of doctors of the medical school from fifteen to twenty per cent. Most of the students have applied for and received commissions in either the Army or Navy. The medical school faculty has been considerably depleted by the call to active duty. The following members now being in the service:

Drs. Millett, Jarvis, Newman, Etzenhauser, Pendleton, Gripkey, Coburn, Erni, Ziegler, Schutz, Bills, Ellis, Ryan, Frick, Lowry.

Medical School is also developing an Evacuation Hospital No. 77. This organization is now completed and is under the direction of Dr. E. H. Hashinger. It comprises a medical division as well as a surgical division. The following faculty members are on this service:

Surgical Division: Drs. J. B. Weaver, Wayne Bartlett, T. G. Dillon, Howard Snyder, M. J. Rumold, T. G. Duckett, M. S. Harless, William Kuhn, F. A. Carmichael, Jr., C. Brown, Wendell Grosjean, Nathaniel Soderberg, Paul Harrington, Glen Franklin, Melvin Rabe, Gale Poole, Ross Newman and Forsythe.

Medical Division: Drs. E. H. Hashinger, M. H. Delp, Maurice Snyder, Jim Fisher, Max S. Allen, Campbell Voorhes, and McConchie.

Dentistry Division: Drs. Jack O'Donnell, R. E. Menees, Howard Dukes.

Laboratory Division: Dr. Tom Hamilton.

X-Ray Division: Dr. John Bowser.

The following fellowships are still in progress in the Medical School: Breon Fellowship being held by Dr. Lulich; Dorothy Hixon Clendening fellowship in medical research held by Dr. J. A. Schnedorf. The

Boyland Fund has also provided funds for the continuation of Malta fever studies.

Dr. Arthur E. Hertzler has contributed numerous surgical specimens for the development of the Pathological Museum in surgical pathology. This material formed the basis for the recent monographs on surgical pathology. Not only does it include the specimen but slides, plates and other data to enable residents and interns to make a complete study of this material. This new unit is housed in the Hixon Laboratory for Medical Research. The Pediatric Department recently received a contribution of \$500.00 for the special investigation of lipoid nephrosis. This was contributed by Meade-Johnson and through this some interesting studies in this condition were carried out.

Relative to the action of the students regarding their military status the following data may be of interest: Of the Senior students forty-five have applied for commissions in the Army and thirty-four to the Navy; of the Junior students forty have applied to the Army and thirty-two to the Navy; of Sophomore students thirty-three have applied to the Army and twenty-six to the Navy; of the Freshmen students fifty-three have applied to the Army and Navy and many of them are still sending in their applications.

The following is the report submitted by Philip W. Morgan, M.D., Chairman of the Committee on Control of Heart Disease:

TO: THE HOUSE OF DELEGATES:

Meetings of the Committee have been kept to two during the year through the use of correspondence.

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** *Laryngoscope*, Feb. 1935, Vol. XLV, No. 2, 149-154.

The third annual cardiovascular refresher course was sponsored by the Committee and given by Dr. Tinsley Randolph Harrison in Emporia, on September 29 to October 2, 1941, inclusive, to thirty-one Kansas physicians. The matriculants were again as enthusiastic about the course as were the members of previous classes. Thirty-two men have signed for the fourth course which will be given by Dr. Sam Levine of Boston this fall. As a courtesy two matriculants from each of the states bordering Kansas will be accepted for this Fall Course.

The Committee sponsored a dinner meeting last May during the Medical Society's Meetings in Topeka. The out of state guest speakers Dr. Landis of Virginia and Dr. Smith of Nebraska were the guests and the crowd exceeded the room space reserved for it.

Unsettled conditions and heavy demands at home prevented the Committee accepting an invitation to present an exhibit at the American Medical Association in Atlantic City. For the same reason no exhibit was prepared for the Kansas State Meeting this Spring.

The Committee considers its important objective of stimulating Kansas physicians study of and interest in cardiovascular problems as progressing satisfactorily. To date it is felt lay publicity is not indicated.

The following is the report submitted by Arthur D. Gray, M.D., Chairman of the Committee on Venereal Disease:

TO: THE HOUSE OF DELEGATES

The war has greatly increased the responsibility of your Committee on Venereal Disease. There is an enormous increase in the activity at our two Army Posts, with the centralization of large numbers of young men. New plants for the production of war material and supplies are requiring the services of workmen in numbers heretofore unknown in the State and in localities where the housing accommodations are entirely inadequate, and living conditions bad. In this environment prostitution flourishes with its inevitable by-product of venereal disease. The Society should go on record condemning any form of prostitution, and favoring its suppression by law enforcement agencies. The Society should approve the agreement by the Army, the Navy, the United States Public Health Service and the State and Territorial Health Officers as the best method of control of venereal disease in the United States armed forces and the war industries.

Your chairman, representing the State Medical Society and working with the State Board of Health and the Federal agencies, has been given the opportunity of cooperating with the Army officials in checking the conditions around points of military concentration. This cooperation has been of mutual benefit.

One extremely interesting and entirely new aspect of the Venereal Disease Control program is the Rehabilitation Program for selectees rejected because of positive serology. It is believed that a plan has been

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devised in cooperation with the State Board of Health, the State Selective Service System, the Selective Service Boards and the local medical societies by which these men will be supplied with sound advice and referred to their private physicians, or treatment provided for them in those instances where they are unable to pay for proper treatment.

Legislative matters are headed up by the persistent proposals for premarital and prenuptial laws. These have been adequately dealt with by the Committee from time to time. Committee members are giving the question study in their various communities. Whether public opinion will demand further consideration of these proposed statutes at the 1943 session of the Legislature remains to be seen. When every angle of this question is considered it is obvious that it has many dangerous aspects.

One new clinic has been established during the year, at Manhattan. The usual policy of requiring the local medical society to request and approve the clinic was adhered to. With the development of the military activities in the State, it is probable that a number of new clinics will be established during the coming year.

The following is the report submitted by A. E. Gardner, M.D., Chairman of the Committee on Necrology:

TO: THE HOUSE OF DELEGATES:

I wish to inform the Society that the following of our members have died during the year on the dates and from the causes described. The report covers the period from April 1, 1941, to April 1, 1942.

NAME	AGE YEARS	DATE	PLACE	CAUSE
Edward, James Burrow	73	April 4	Fort Dodge	Paralysis agitans

Tolle, Frank Elbert	33	May 3	Overland Park	Acute pulmonary congestion, edema of brain
Poutre, Fred G.	53	May 9	Greenleaf	Coronary occlusion
Vander W'yst, Petros G. W.	64	May 29	Altoona	Nephrolithiasis, hypertension
Dillenbeck, Frederick Emmett	74	June 5	ElDorado	Bronchial pneumonia
Collins, Melvin	80	June 9	Wakefield	Chronic nephritis
Graves, Walter H.	88	June 14	Wichita	Injury sustained in automobile wreck
Gray, Robert E.	79	June 17	Garden City	Injury sustained in automobile-train wreck
Bourse, William George	66	June 20	Goff	Senile dementia
Robson, Robert R.	85	July 7	Mayetta	Carcinoma of the sigmoid colon
Yohe, Alfred F.	76	July 23	Leavenworth	Parkinsons syndrome
Adkins, Evelyn Leon	68	Aug. 5	Lerado	Broncho-pneumonia
Growney, Lawrence E.	46	Aug. 9	Kansas City	Myocardial degeneration
Rogers, Alfred Hezekiah	78	Aug. 14	Hepler	Coronary thrombosis
Talbot, Harrison B.	53	Sept. 30	Topeka	Poliomyelitis
Brown, Andrew P.	32	Nov. 3	Panama City, Florida	Diabetes with gangrene of foot
Maust, Calvin H.	65	Nov. 4	Lecompton	Coronary occlusion
Sarchet, Lloyd Henry	69	Nov. 14	Wellington	Carcinoma of lung
Mosley, Charles L.	55	Nov. 25	Fort Scott	Aortic stenosis
Felix, Tasso O.	80	Dec. 12	Denver, Colo.	Coronary thrombosis, coronary sclerosis
Vermillion, Clinton D.	73	Dec. 27	Salina	Hypostatic pneumonia
Bell, Fred H.	60	Jan. 12	Baldwin	
Breeding, Walter Raleigh	77	Jan. 9	Marysville	
Hawley, Joseph Edward	90	Feb. 11	Burr Oak	

May I suggest a few minutes of silence at this time in honor of our departed members.

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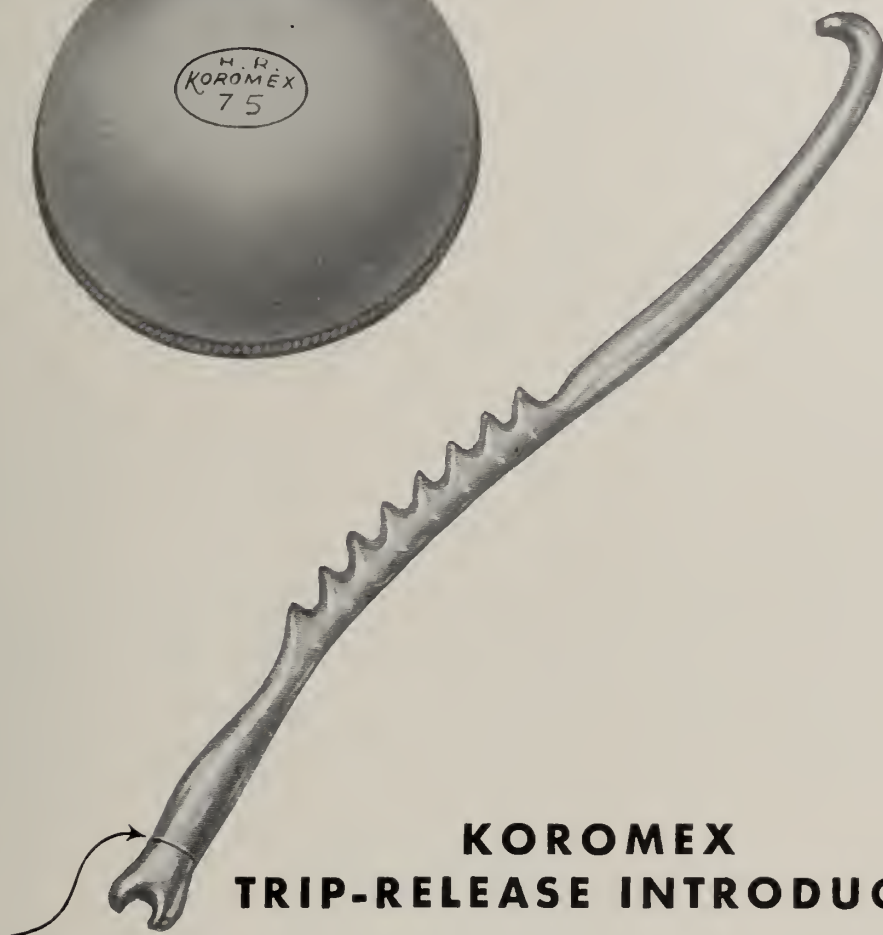
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The Journal Of THE KANSAS MEDICAL SOCIETY

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Volume XLIII

MAY, 1942

Number 5

PRESIDENT'S ADDRESS

Clyde D. Blake, M.D.

Hays, Kansas

At the close of the year for The Kansas Medical Society, it is well we observe in retrospect some of the Society's activities throughout the past twelve months.

The untiring efforts of the various committees have been certainly appreciated. Things have been accomplished and others are well along the way of accomplishment. To them and our most efficient Executive Secretary, Clarence Munns, goes the credit for the many activities throughout the year. It is certain our Society has not been static and another step forward in the program of organized medicine in Kansas has been achieved. Time will not permit, nor is it desirable here, to tabulate the activities of the many committees, as they appear in the Journal and may be reviewed at your pleasure.

I cannot, however, fail to mention here what seems to me to be an outstanding continued activity of the Society as a whole for several years, and I am certain will continue as a major activity throughout the years ahead. The building up of a bulwark of public esteem and confidence, the value of which has so marvelously contributed to the success of our efforts in quack and cult control; the regulatory efforts in food and drug control; the lay educational programs carried out each year in conjunction with the Public Health Services and State Board of Health and to mention only a few: the cancer educational program; the recognition, control, and treatment of tuberculosis; the study of heart disease, the greatest killer of them all, its etiology, its recognition, and its treatment; maternal welfare; child welfare; conservation of eyesight; industrial medicine; automobile accidents and fractures; the reporting, recognition, and control of venereal disease. How well I would like to recite in detail the accomplishments of the above committees and when you read their annual reports, just remember that the ever manifest modesty of

physicians will be exemplified in these reports and they will in no way fully tell the story of sacrifice of time and the effort required in the planning for further progress of medicine in Kansas. These are the activities that build trust and confidence of the general public today.

Let us now consider for a moment some of the groups more intimately associated with public relationships. The Committee on Public Policy, working quietly without flags or fanfare, exerting at all times through personal contacts rather than public utterances a wholesome and effective influence on public opinion.

No less outstanding in building public appreciation is the work of the Committee on Public Health and Education. Here through the contacts with the State Board of Health, the State Board of Social Welfare and the many other agencies entering into the field of physician-public relationships. They have been able through a spirit of timely advice and guidance to protect us from many pitfalls and unwholesome relationships that, without the watchful care of this Committee, might have unthoughtedly placed medicine in undesirable situations.

The Committee on Allied Groups render a valuable service in building up public opinion through the medium of better understanding between our Society and the groups closely allied in similar public service and by this means widen the scope of general public appreciation.

That ever present problem of medical economics, an octopus in type with its tentacles reaching out in many directions, through many agencies, must continue to be one of our greatest concerns. At no time in the history of medicine has there been so many ideas and proposed plans to furnish medical care, hospital service, dental care, and drugs at a minimal cost per capita. All of which have arisen following the survey to determine the high cost of medical care, resulting in a majority report and a dissenting minority report from the federal committee personnel.

From personal observation, it is gratifying to note that before final action is taken by lay groups, the advice and council of representatives of our Society

*Presented at the 83rd Annual Session of The Kansas Medical Society, Wichita, May 13, 1942.

is sought and up to this time no radical action has been taken in the acceptance of any fantastic unworkable plan for complete medical care. It has been deemed advisable by your Committee on Medical Economics that thoughtful guidance and timely advice would be most desirable to forestall a situation unsatisfactory to the general public and physicians alike. And I am pleased to state that so far, through careful planning, the situation has been controlled, in so far as Kansas is concerned.

A new committee with a valuable task at hand in collaboration with a like representation from the Kansas State Bar Association has laid the groundwork for future activity as relates to physician-legal relationship, that in the end will greatly assist in revamping obsolete laws, or their repeal and in their place recommend laws modernizing the position of coroner, rules and regulations for the improvement of medical testimony, devising methods for the purification of expert testimony, and I use the word purification advisedly, as there is no phase of medical-legal relationship that engenders public distrust so much as the type of conflicting expert testimony observed in many cases today, and many other valuable possibilities being considered by this valuable committee.

One other committee born of necessity in the war emergency has of necessity been active and has contributed much in a constructive way in the defense program and war activities so vitally necessary during the war period.

Time will not permit of only passing mention of other groups that have so ably contributed throughout the year in rendering The Kansas Medical Society a recognized active group outstanding in accomplishment in the field of organized medicine; namely, the Auxillary Committee; the Committee on Constitution and Rules; the Defense Board, the Committee on Endowment; the Executive Board; the History Committee; the Committee on Hospital Survey; the Committee on Locations; the Committees on Medical Schools, the Committee on Pharmacy, Scientific Work, Library, and Necrology.

Again let me express my sincere appreciation for the valuable services rendered the Society throughout the year, and may I assure our incoming President, Dr. Henry N. Tihen, the same cooperation of the officers and members of the Society for the coming year, and be assured another step in medical progress will be attained in the months to follow.

It has been a pleasure to serve with and for this splendid group of professional people, known as The Kansas Medical Society. Thank to all.

Having completed the above report of the years activities of the Society, I wish to turn now to a subject of vital importance to all of us, namely, Ameri-

can medicine in a world at war, and to ask you if you believe that we are meeting the challenge suddenly thrust upon us by our American Countries entry into this World War.

At no time in history have the duties imposed upon us been so great. Our government has exemplified the utmost confidence in us when it says the job of procuring and assigning for duty in the Army, Navy, Public Health Service, and in Civil Service is yours.

Your government will assist you in this all important undertaking by placing at your disposal the necessary physical and legal machinery or performing quickly and efficiently this enormous task. You will have at your disposal the services of the offices of Procurement and Assignment, through which mediums you will deliver to us for service in the Army, Navy, or public health, men of your profession who are physically qualified, skillfully trained, and of unquestioned character and experience in various fields of medical practice, and also maintain adequate medical service for the civilian population. Keeping ever in mind that your foremost duty is to your country in placing at its disposal, upon demand, the best you have in medical service today.

What greater exemplification of confidence and trust in this time of the greatest national emergency that has ever arisen in the entire history of our country. Where and when the very foundation of civilization is all but crumbling under the impact of the most devastating and destructive forces that man, by his intelligence and ingenuity, could devise. In such a time where a few months ago the task of organization, preparation, and production seemed insurmountable our government says to us as men trained in the greatest profession of all time—Here is your job! It will be necessary on demand that you place at the disposal of the Army, Navy, and Public Health Services your most physically fit, your most thoroughly trained in the arts and science of medicine. These qualified men by the thousands, yes, probably forty to fifty thousand in the comparatively short time of two years. This number of necessity must be garnered from a possible group of 130,000 physicians now in more or less active practice in the United States.

These men are wanted to care for an army of ten million men—our Army and our Navy. The greatest Army and Navy of all the world. Greatest in point of physical fitness; greatest in point of intelligence; greatest in point of adaptability; greatest in point of bravery, loyalty, and ingenuity of all the far flung armies and navies of the entire world.

We, as men of medicine of Kansas through our organized Society, a component part of national or-

ganized medicine, have accepted that challenge and this obligation must be filled.

Not only for the armed forces, but a further responsibility is ours. The care of the civilian population. To accomplish this task the utmost in self denial, sacrifice of time, financial gain, professional prestige must all be relegated in obscurity until such a time as the United Nations may emerge victorious in this the greatest of all wars. To accomplish this task we have pooled our resources and responded to our country's call en masse irrespective of age, physical ability, or professional attainments, and through the medium of questionnaires have endeavored to give our government all information pertaining to professional qualification, physical ability, burden of dependencies and personal desires as relates to capacity to serve throughout the period of emergency, as determined by our democratic government. A type of government giving to us liberties and freedom of accomplishments and fullness of reward for personal achievement—the like of which is not assured by any other nation of the world.

It will be true that all responding to the call for service will not in all instances be assigned to duties deemed most suitable from our personal point of view, but our assignments will be such as will best fit into a pattern that will assure the highest type of medical service possible for the Army, Navy, public health, and civilian population. It now seems probable that one out of every three medical men of our nation will be called upon to serve in some capacity directly as a part of war activities.

The enormity of this task seems staggering. We, of organized medicine have faith in our ability to serve and by that faith accomplishment will be assured. Not only must the medical men strive to serve to their limit of endurance, but also the civilian population must in a spirit of cooperation spare the physician of all minor demands upon his time, in order that he may be sustained in health to serve to the limit of human endurance. To this end the general public should by every means inform themselves as to methods and means whereby they maintain themselves in vigorous health throughout the duration. Also, the general public should be instructed in methods of service and self-reliance in minor illnesses and emergencies, as a well informed public in a spirit of cooperation are the prime factors in prevention and control of epidemic diseases. The scope of which, as we all too well know, might gravely handicap our war efforts.

To this educational task comes the Public Health Service with its trained personnel continuously instructing and supervising in the training of our people in matters of health and disease control. Thus,

through this service another vital link is forged in the chain of war effort.

Hence, let us be aware of the enormity of our task. Let us also be aware of the importance of our task, and by this recognition of duty imposed, we will not fail in supplying to the Army, Navy, Public Health Service, war industries, and civilian population, adequate medical care. To this end the most perfect cooperation and organization is required. No shirking of responsibility can be tolerated. No special privileges should be sought or granted. Each must accept his task as a personal responsibility and carry on to the utmost of physical endurance until the emergency has passed. Thus may we exemplify to our government through its various agencies our willingness to serve—not as a trust or union demanding special privileges and fixed compensation—but true to the tradition of medical practice in service to our government and our fellow man.

Failure to avail ourselves of this opportunity in voluntarily responding to our Nation's call could only result in the breaking down of the most rational and liberal program for furnishing in this military emergency the men most suited to serve the Army, the Navy, and the Public Health Services; and in its stead, of necessity, resorting to the system of draft in the selection of men of suitable age and professional ability for service in supplying government needs. Such a failure would provoke and merit the criticism of our government, and an undesirable state of public opinion that would require generations to overcome. I am certain that American medicine will not countenance such disaster.

The desirable conclusion of this emergency medical program does not mean supreme leadership of a few, but the voluntary cooperation of all. Again let me say, the machinery, the most liberal ever known, is operating by the supervision of medical men. Our own men, if you please, let us cooperate one hundred per cent in the program and win for us the highest respect of our government, and the undying gratitude of the men who are in the midst of the fight and are sacrificing all, even life, in our Nation's cause. The parents, relatives, and friends of those who serve at the fronts will hold us in highest esteem. Time, money, and prestige are nothing in point of sacrifice as compared to our boys and men who bear the impact of battle, in the air, on the ground, and on the seas. Let us serve in whatever capacity assigned us until the emergency is past, and when peace comes we may look forward to a greater, grander, American medicine that will merit and receive a place of highest esteem in the entire world.

A preview of post war conditions—We, as medical men of today, must be ever mindful of future

needs. American medicine has for a generation been forging ahead until today she is at the pinnacle of medical progress. In surgery, medicine, and research she has no equal, while other countries, because of wars and preparation for war, of necessity have been forced to curtail training, which will in the near future be more greatly manifest than at the present time.

The leadership is ours. No longer is it possible or desirable to seek training in foreign lands, as of a few decades ago, but rather, training of the arts and science of medicine, surgery, and research will be sought in the future by men from the far corners of the earth. In our clinics and among our practitioners there is and has been medical history in the making. Let us welcome the ever increasing numbers of medical men coming to America to observe and learn of new and improved and better methods in the treatment of disease. Not that they may become part and parcel of our country, but that they may return to their own fields with a sense of high esteem and a feeling of having obtained first hand valuable information in medicine, surgery, and research that will enable them to better and more efficiently serve their fellow man upon their return.

How may we deserve and maintain this prestige. Certainly not by lowering requirements for entrance upon a course of medical training. Certainly not by reduction of time in actual medical training and clinical training. Nor should we countenance the shortening of internship time. Rather let us keep our standards high. Rather let us provide for the training of high type medical material by endowment for those because the cost of medical training at most may be prohibitive.

In this land of fabulous wealth and resources many may be found willing to contribute liberally to a well formulated and supervised program of progress in research and medical training. Physicians not being the benefactors, but the entire population would be the recipients of the total benefits accruing from such a program through the medium of the highest type of hospital and medical care. What greater appeal could be brought to bear upon the philanthropic minded individual than to know, as a donor, that through the means of his or her endowment an invaluable service will be rendered to the populace as a whole through the medium of the highest type of medical training and the most efficient hospital care.

Science should not be relegated to the field of financial gain, but should be recognized and evaluated by the yardstick of achievement.

One other thought which should appeal to all physicians and research workers. May I ask this question—Why have we not in some manner provided

for the men and women devoting their lives in the field of medicine and research, giving little thought of financial gain because of the very character of the service they are rendering. They are apart from the field of commercialization, only asking for their services a mere competence with no thought of amassing means whereby they may at a suitable time of retirement live in comfort throughout the remaining space of a few years. Some plan certainly can be perfected through the efforts of our national society in collaboration with its component groups to erase forever the picture of all too many men of medicine at the turn of the road, because of advancing years, being forced to continue in an effort to maintain a livelihood of respectability and comfort.

In conclusion let us as men and women of organized medicine and research, first; pledge ourselves in service to our country through this period of the greatest of all emergencies. Second; let us maintain the high standards of medical education. Third; let us by some means assist the worthy in pursuing their training through the period of years necessary to fit them for services of the highest order in a profession the peer of all professions. Fourth; let us by some means formulate a plan whereby men of our profession who have devoted their lives in the service of humanity, without thought of financial competence, find themselves at retirement age compelled to carry on in an effort to maintain a respectable livelihood in the declining years when rest, comfort, and enjoyment should be their lot, may be amply provided for in their declining years. Unlike other fields of endeavor, when the physician fails to function his capital stock is exhausted, his stock in trade has been disposed of, and unless through fortunate circumstances he has wisely provided for the period of advanced years, which in our profession is all too infrequent, he is compelled to carry on until death or total disability may force him to dependency, or even charity until the close of his day.

Seventy-eight University of Kansas medical students in Lawrence are now enrolled in classes for first-aid under the civilian defense plan, with training as orderlies in medical field units for defense organization. All enrollment is voluntary and thirty hours of work will be completed under the supervision of Dr. R. I. Canuteson, health service director of the University of Kansas Watkins Memorial Hospital; Dr. Parke Woodard, associate professor of physiology; Dr. Glenn Bond, assistant professor of bacteriology; Dr. C. W. Ashling, instructor of anatomy; and Dr. Ronald Vetter, resident physician at Watkins Hospital.

THE VITAMIN REQUIREMENT FOR INFANTS AND CHILDREN*

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In spite of — indeed, perhaps, because of — the voluminous literature on vitamins in the current journals, the practicing physician or pediatrician is left most confused as to optimal nutritional standards with respect to every vitamin from A to K. A plethora of articles on these interesting substances from B-ionone-diisoprenol to 2-methyl 1, 4 naphthoquinone leaves the reader still uncertain as to the answer to three simple basic questions: 1. What is the optimal amount of the various vitamins which should be supplied daily to the infant and child? 2. To what extent is the average American diet deficient in these substances? 3. How may such a deficiency best be corrected? Efforts to supply the answers led the Canadian Medical Association to publish a monograph entitled "Nutrition in Everyday Practice," which compiles a series of articles on nutrition which had appeared in the Canadian Medical Association Journal during 1938-1939, sponsored by their committee on nutrition. More recently, the committee on vitamins of the American Academy of Pediatrics studied the problem and published a report in December, 1940. I shall use these two publications extensively in continuing this discussion.

VITAMIN A

Vitamin A is B-ionone-diisoprenol. It is formed in the animal body from those carotinoid plant pigments which contain a B-ionone ring. B-carotene, the most important precursor, is simply two vitamin A molecules linked together end to end. The vitamin occurs in animal tissues as an ester, and is ingested as such, saponified in the intestine, and absorbed through the intermediary action of bile salts and lipase in the intestine. After absorption, vitamin A is re-esterified and stored in the liver in amounts large enough to provide protection against deficiency during periods of inadequate intake.

Vitamin A is essential to the normal structure of epithelial tissues, a deficiency resulting in the replacement of the specialized epithelial cells of glands and of respiratory, gastro-intestinal and urinary tracts by keratinizing squamous epithelium. It is a component in the visual purple of the retinal rods and so is essential for visual adaptation in dim light. It has no "anti-infective" protective role except through the prevention of epithelial metaplasia.

A complete or very marked lack of vitamin A results in the deficiency disease, "Xerophthalmia," characterized by a peculiar ground glass appearance of the eye and the development of corneal ulcers. The characteristic epithelial changes also may result in hyperkeratosis of the skin and respiratory tract infections. Partial lack of the vitamin causes night blindness, a loss of visual acuity in dim light.

The exact vitamin A needs of children and adults are unknown. Animal experiments indicate that a minimum of twenty I.U. or six micrograms of vitamin A per Kg. per day is necessary to prevent night blindness. A daily minimal requirement may be considered to vary from 0.06 mg. or 200 I.U. for the infant to 0.42 mg. or 1,400 I.U. for the adults. The needs for prevention in adults of any detectable impairment of dark adaptation suggests a "physiologic requirement" of double these figures. And, since evidence of storage of the vitamin in adults has been obtained only after ingestion of three times these minimal amounts, the optimal requirement may be stated as 0.18 mg. or 600 I.U. for the infant and 1.2 mg. or 4,000 I.U. for the adult. Fortunately vitamin A is the most widely and abundantly distributed of all the vitamins. It is present in large amounts in milk fat, in colored vegetables such as carrots, spinach and tomatoes, and in egg, liver and kidney. Two teaspoonsful of standard cod liver oil provide nearly 7,000 I.U.; ten drops of a standard concentrate of cod liver oil or Percomorphoil give 13,300 I.U. A pure dietary deficiency without the contributing factor of long standing faulty intestinal function is rare. Diabetes and hypothyroidism may interfere with the normal conversion of carotene into vitamin A.

The normal child, therefore, on a reasonable diet will suffer no lack of vitamin A, and requires no additional amounts in concentrated forms. No toxic effects have followed the administration of large doses to human subjects. Large doses of carotene may produce hypercarotenemia in some individuals.

VITAMIN B. COMPLEX

"Water Soluble B" was the term applied in 1916 to the antiberiberic vitamin described in the studies of the Dutch investigators from 1897 to 1911. In 1926, it was shown that this vitamin consisted of at least two factors, one heat-labile and one heat-stable. The heat-labile or antiberiberic factor was called vitamin B₁, and was crystallized in pure form as thiamin chloride in 1936. In 1933, a definite substance, later identified as riboflavin, was isolated from the heat-stable factor, and was designated as B₂ in the European literature and G in American literature. About the same time, another factor, found to be essential for rats, was separated from the heat-

* Presented at a meeting of the Wyandotte County Medical Society, Kansas City, October 21, 1941.

stable fraction and subsequently proved to be pyridoxine. The pellagra preventing factor was shown in 1937, to be nicotinic acid. Still later, pantothenic acid, essential for rat and chick was separated from the heat-stable complex. Thiamine, riboflavin, and nicotinic acid have been amply demonstrated as necessary for human nutrition.

Thiamin chloride hydrochloride is the form in which vitamin B₁ is crystallized. Thiamin is necessary in the metabolism of carbohydrate and in the formation of fat from carbohydrate. It is linked with phosphoric acid in the body to form the coferment cocarboxylase, in the absence of which, carbohydrate metabolism does not proceed normally and pyruvic acid accumulates in the tissues. A moderate deficiency of thiamin may result in poor appetite, diminished rate of growth and increased fatigability, symptoms which may occur in moderate deficiency of many essential food substances and which are not specific signs of thiamin deficiency. Marked deficiency results in beriberi, characterized by neuritis, nerve atrophy, loss of reflexes and paralysis, gastrointestinal disturbances, pallor, enlargement of the right side of the heart, rapid pulse, and sometimes edema.

The optimal daily requirement of thiamin has not been accurately determined. It has been suggested that infants should have 0.18 to 0.3 mg. (60-100 I.U.); children, 0.3 to 1.5 mg. (100-500 I.U.); adults, 0.75 to 1.5 mg. 250-500 I.U.) per day. Elevation of the metabolic rate, such as occurs with hyperthyroidism or fever, increases the need for thiamin. The need for thiamin is less with a high fat diet and greater with a high carbohydrate diet. Vitamin-B₁ is widely but not abundantly distributed in foods, the best common food sources are whole grains, milk eggs, liver, lean meat (particularly pork), vegetables such as cabbage, carrots, spinach, beans and peas, and oranges and tomatoes. However, forty-two per cent of the calories consumed in the average diet are from foods practically devoid of the vitamin. Also, the vitamin is fairly readily destroyed by cooking in neutral or alkaline medium, and a substantial loss occurs in discarded cooking water. As a result the average diet consumed today in the United States and Canada tends to be low in thiamin. One and one-half pints of milk provide 200 I.U. of vitamin B₁, so the requirement for infants may be fairly adequately met by the average formula. An adequate intake may be maintained as the infant grows older by the addition to the diet of vegetable purees, liver soup, egg, and proprietary cereals reinforced with wheat germ and yeast. If a deficiency is still feared, the use of a concentrate of so-called "B-Complex" is justified. There is no evidence of any toxic effect

from thiamin, even with repeated massive doses.

Riboflavin (6.7-dimethyl-9-(d'ribyl)-isoalloxazine) is necessary for the metabolism of practically all living cells, playing an important part, combined with phosphoric and adenylic acids, in cell respiration. This vitamin has a rather wide and abundant distribution in foods. Rich sources are liver, kidney, heart, lean meat, milk, cheese, eggs, green leafy vegetables, legumes, whole grain cereals and yeast. Deficiency is a rare occurrence except in certain areas of Alabama where deficiency diseases are endemic. Outstanding symptoms are nasolabial seborrhea, cheilosis, a glossitis of magenta color, and ocular lesions. The exact requirements for riboflavin are unknown; 1.5 mg. has been suggested as the daily requirement for children up to ten years, and two mg. for adults (500-700 Sherman units, respectively). A diet adequate in vitamin B₁ is likely to be adequate in riboflavin. There are no toxic effects from heavy dosages.

Nicotinic acid (3 pyridine carboxylic acid) also plays an important role in carbohydrate metabolism and tissue respiration. Very meager data suggest a daily requirement of about 0.3 mg. per kg. of body weight. Liver, lean meat, yeast, wheat germ, milk and eggs are all comparatively rich in nicotinic acid. Deficiency results only from the most restricted diet such as corn and salt pork, or alcohol, coffee and doughnuts. Marked deficiency results in pellagra. However, clinical pellagra is usually associated with multiple deficiencies. Large doses of nicotinic acid may cause itching, tingling and flushing of the skin, but these symptoms pass off in a short time without harmful effect.

A point of great practical importance is that when one of the members of the vitamin B complex is deficient in the diet, the other members also are usually deficient to some degree. Moreover, the chemical reactions of normal tissue respiration involve an interdependence of the several factors.

VITAMIN C

Vitamin C or ascorbic acid is essential to the formation of normal mesenchymal intercellular material. Its lack results in an increased permeability of the capillaries so that there is a tendency to bleeding. Such hemorrhages under the periosteum at the ends of long bones and in the gums give rise to the typical signs of scurvy. Rich food sources of the vitamin are the citrous fruits, berries, green peppers and raw cabbage. Milk is a relatively poor source of vitamin C and pasteurization or boiling destroys most of its ascorbic acid.

The optimal requirement has not been accurately determined but at present, tentative estimates for fairly adequate ascorbic acid intake are twenty to forty mg. for infants from birth and forty to sixty

mg. for children and adults. These quantities are provided by two to five ounces of orange or grapefruit juice and three to eight ounces of canned tomato juice. Tablets of crystalline ascorbic acid, of course, are available. No toxic effects have been observed after administration of excessively large doses.

VITAMIN D

There are two forms of vitamin D of importance in medicine; activated ergosterol, or calciferol, D₂; and activated 7-dehydrocholesterol, D₃. The vitamin acts to increase the absorption of calcium and phosphorus from the gut, the retention of these elements in the body and the increased urinary excretion of calcium. The increase in the product of concentrations of serum calcium and phosphorus establishes more favorable conditions for the deposition of lime-salt in osteoid tissue. Very little is definitely known about the mode of action of the vitamin upon bone.

The minimal requirement for infants and children up through adolescence is approximately 400 I.U. daily or ten micrograms of vitamin D. Premature infants probably need 600-800 I.U. Some students of the question have advised as high as 2,200 I.U. as optimal dosage. Ordinary foods contain very little vitamin D. Fish, butter and eggs are the best sources in that order. During the three summer months, ultraviolet light from adequate sun baths may supply enough vitamin D by activating the provitamin of the skin, 7-dehydrocholesterol. To fill the need at other seasons, it is essential to give the growing infant or child suitable doses of cod liver oil or other fortified or concentrated fish liver oils, or irradiated or fortified vitamin D milk. Ten drops of *Oleum Percomorphum* supply 1,850 vitamin D units and 13,300 vitamin A units. Two teaspoons of a good grade cod liver oil supply 1,400 I.U. of vitamin D and 14,400 I.U. vitamin A. Maximum antirachitic doses of vitamin D produce no toxic effects. The continued use of excessive doses (100,000-500,000 I.U. daily) may increase the product of serum calcium and phosphorus to extreme levels and bring about metastatic calcification.

VITAMIN E

Vitamin E, alpha tocopherol, the antisterility vitamin for rats, has not been demonstrated to have any great importance in the nutrition of the child. It is so widely distributed in many foods that it is unlikely that children receive an inadequate supply. The best sources are cereal and vegetable oils.

VITAMIN K

Vitamin K occurs naturally in at least two chemical forms, both of which are essentially a naphthoquinone with long carbon side chains so that in one case four isoprene units may be obtained, and in the

other, six such units. More than forty-five synthetic substances possessing K-activity have been reported. The vitamin appears to be essential for the normal synthesis of prothrombin in the body, but the mechanism of this action is unknown. Vitamin K occurs in the photosynthetic portion of many plants and in some vegetable oils (soy bean oil). Vitamin K₂ is obtained from putrified fish meat. Certain bacteria can synthesize the vitamin and this may occur in the human intestinal tract. No adequate data are available as to the daily requirement. Its chief importance in pediatrics is in the control of hypoprothrombinemia and the hemorrhagic diathesis of the newly born, 0.5 mg., perhaps repeated in twelve to twenty-four hours, effectively controls such bleeding. No toxic effects have been observed following the administration of doses up to 1,000 times the therapeutic dose.

In brief summary of this discussion, we may legitimately conclude that the normal infant receiving calorically adequate amounts of breast milk or a supplemental cows milk formula plus two ounces of orange juice and two teaspoonsful of cod liver oil or their equivalents is in no real danger of a vitamin deficiency. The older child is equally well protected on a diet which includes one to one and one-half pints of milk, one egg, two vegetables beside potato (cooked with as little water as possible) and some raw fruit or raw vegetables, plus some additional source of vitamin D except during the three summer months.

IDEAL COMMITTEE MEMBER

It might be interesting to consider the ideal member of a committee. What are his qualifications and how does he meet his responsibilities?

First, he should have the interests of the medical profession at heart.

Second, he will give thought and study to the subjects which come up before the committee and will not be just one of those present.

Third, he will make it a point to be on hand for all meetings unless his professional duties require him elsewhere.

Fourth, he will not allow one or two men to assume the entire burden for developing plans, but will contribute ideas of his own.

Fifth, he will do what he can to make the meeting orderly and not overlong.

—Medical Annals, District of Columbia.

According to statistics recently issued by the Institute of Life Insurance, the average U. S. citizen in 1941 carried approximately \$925 in life insurance, which is an all-time high.—Ohio State Medical Journal.

PREFRONTAL LOBOTOMY IN THE TREATMENT OF MALIGNANT MENTAL DISORDERS

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Neither surgery of the central nervous system or an attempt to apply surgical therapy toward the relief of various types of mental disturbances is new or revolutionary. Anthropological findings reveal both in the skulls of the ancients and by legend, previous attempts of man to fathom the unknown of the human mind, and to liberate it from confusion and travail by surgical procedures upon and within the skull. Today we have for consideration such a procedure which has now been tempered by years of experience, by scientific observation and experimentation, and which is based for the most part on some but not all of the physiological facts relative to the function of the nervous system in general and the anterior cerebrum in particular.

Today our concept of the function of the higher centers of the human brain are based on long, devious and fruitful courses of experimentation beginning with the observations of Gennari in 1776 of the special structure of the calcarine cortex which still bears his name. Indirectly from this observation came the science of architectonics finally culminating in the description by Broadmann which assigns the cerebral cortex to areas correlated with their cytological design. These observations combined with accurate and enthusiastic experimentation by neurophysiologists established most of the concepts upon which the operation under discussion is based. Even now, certain essential and available correlations are possible which might permit a more accurate appraisal of this procedure. It has been repeatedly pointed out and I think correctly so, that conclusions regarding the frontal lobes cannot be drawn from instances in the literature which recount the resection of the frontal lobes for tumor, abscess or trauma because of the very great possibility that the physiologic affects were not specifically restricted to the areas of the lesion.

In the field of animal experimentation, notably the studies carried out by Fulton and Jacobson¹ who resected the frontal lobes of chimpanzees, it was observed that subsequently the animals were incapable of "worry," and incapable of going into rages which had previously occurred upon failure to perform a test problem with accuracy. These investigators like-

wise found that such a prefrontal lobectomized animal was unable to retain even for a few seconds the memory of recent events in the face of other new incoming sensory experiences. Likewise, it was observed that in such animals, while there was no definite or actual motor disturbances, there was a clumsiness manifested which was presumably due to inability to organize movements in coordinated patterns of motor response. Bianchi² reported the tendency of such animals to have a ravenous appetite but exhibiting loss of weight in spite of this fact. He found such animals quite distractable, frequently shifting their activity from one objective to another so rapidly that the result is purposeless.

It was apparently these physiological facts which prompted Egas Moniz³ in 1936 to attempt the application of surgical procedure to psychotic patients. He was quickly followed in this country by Watts and Freeman in 1937,⁴ and later by Lyster,⁵ Love,⁶ and others. The operation is usually undertaken under local anaesthesia by means of a bilateral small trephinations in the plane of the coronal suture, through which by direct observation as carried on by Lyster⁷ or indirectly according to the technique of Watts⁸ the white matter is sectioned by a blunt instrument, the procedure being directed toward disconnecting the diencephalon, particularly the hypothalamic area from the prefrontal cortex by a section of the white fiber connecting pathways subcortically in a plane that passes adjacent to the anterior tip of the lateral ventricle and the posterior margin of the sphenoid wing. The surgical attack upon mental disturbances has come repeatedly under severe criticism as representing a radical form of therapy, but in order to fairly appraise this criticism a survey of the record is illuminating.

When in the far distant past a sufferer from some mental disease was thrown to the ground and his evil and animal spirits were liberated through a crude cranial opening inflicted with a flint instrument, we can all readily agree that this was radical, but later during the dawn of enlightenment the radical flint craniotomy was supplanted by the advanced thinkers of that day, by beating and ducking, by chaining and torture, by bleeding and purging, as being a more scholarly and effective mode of treatment.

Today our source of procedures from an esthetic viewpoint is not greatly expanded. We have on the one hand a new and admittedly imperfect and incompletely understood surgical procedure of low mortality that has been shown to be highly effective in the relief of certain types of mental disturbance. A procedure that is not fear inspiring, brutal or cosmetically mutilating. That it may be in some degree intellectually mutilating is a presumptive criticism

the justification of which only the future can disclose.

On the other hand we have at our disposal for the same group of patients the so-called shock therapies which promise to, and do restore in certain cases and in certain degree, the normal mental processes of the psychotic patient. Therapy by this method is perhaps as radical as lobotomy and if not regarded as radical must certainly be regarded as heroic. Convulsive therapy carries the potential danger of fractures which even if obviated by the use of Curare have their specific dangers. By comparison it is regarded by some as "conservative." I am inclined to regard the present pharmacologic regime in the treatment of mental illness as probably as radical as prefrontal lobotomy.

To us the pertinent question is, what are the results? Statistically we may assume that approximately fifty per cent of the cases treated by shock therapy are restored to greater or less degree of competency through this method. Relapses are fairly frequent. Just what percentage of cases are reported as permanent cures is not as yet statistically tabulated. On the other hand Freeman and Watts in a series of eighty cases had three operative deaths, in thirty-nine cases Lysterly records none. Therefore, it can be seen that surgically speaking the operation is not particularly formidable and there is every reason to believe that this small mortality can be reduced to a negligible point. The paramount question is, "What are the results from prefrontal lobotomy?" Of Lysterly's series, out of thirty-nine cases 71.8 per cent were followed by beneficial results,⁹ of the eighty patients of Watts and Freeman similarly treated twenty were capable of resuming regular employment, twenty-two were able to keep house, seven were partially employed and only five required continued institutionalization.⁹ In these cases the majority of preoperative psychiatric diagnoses were Involutional Melancholia. In the same publication Palmer stated that by methods of shock therapy seventy-three per cent to eighty-five per cent recoveries in the same group could be anticipated. This appears to be an extravagant statement and not in line with the experience of those who have been using the shock treatment over a period of several years. In evaluating the results obtained in the treatment of cases by lobotomy a very large percentage had previously been submitted to pharmacologic shock therapy without benefit. Another question of considerable significance is the question of permanency in either treatment. We know that relapses after shock therapy are quite common. It is impossible at the present time to state exactly what the long term results of lobotomy will prove to be.

PHYSIOLOGICAL AND PSYCHOLOGICAL RESULTS OF LOBOTOMY

Considering first the physiological effects of the operation, these may be said to be surprisingly insignificant. As the operation is completed on the second side, sweating is usually apparent and if the procedure is carried out under local anesthesia the extremities may become warm and flushed as the vascular tension relaxes. Remotely it has been noted most of the patients, after a lapse of time, exhibit a paucity of motor effort, a disinclination to activity which is manifested equally in speech as in other motor performances. While urinary incontinence has been recorded, in a few instances, there are no persistent or prominent evidences of neurological disorder following the procedure.

In the psychological realm the sequelae of lobotomy are even less well understood. A very definite change in the personality of the individual is noted. Freeman and Watts¹⁰ have aptly expressed this change as a loss of consciousness of self which function these authors believe is mediated by the prefrontal area. Procrastination and mental and physical inertia are usual observations. Freeman and Watts have noted that although some of the preoperative delusional patterns may persist, they are not sufficiently introspectively stimulating to the patient to excite the reaction of concentration or of further elaboration. As more clearly put by Freeman, there is "emotional bleaching" in relation to these ideas. The general change in personality seems to be in changing the direction of interests from within to without.

The statement has been made that results equally as good as those secured by lobotomy may be obtained by psychotherapy in selected cases. Granting the validity of this statement we must consider carefully the word "selected." Psychotherapy to be effective must be carried on over a long period of time; only a small fraction of psychotics requiring hospitalization are suitable subjects for this technique. Its application to patients in state hospitals is possible only in a negligible number because such hospitals are inadequately staffed and are unequipped to administer this form of treatment. The amount of time consumed makes it prohibitive. The results obtained from this method have not been uniform. Extravagant claims are made by some that are difficult to confirm while others regard this method as useful only as an adjuvant.

On the other hand, the operation is relatively simple, quick and inexpensive. It could be applied by a single surgeon to several patients in a single day. In contradistinction, apparently, the operation rarely requires reapplication. These practical considerations

deserve profound thought when these two methods are compared.

In the present state of our rather nebulous conception of mental mechanisms and the causes intrinsic or extrinsic leading to mental deviations, intemperate criticism of any method, medical, surgical or psychologic that produces favorable results or partially relieves the distress of the sufferer have little justification.

A large and necessary gap remains in our knowledge of lobotomy before final appraisal may be made of it. So far, post-operative observations have been somewhat hampered by the fact that in most instances there is no comparative data at hand with which to precisely compare the post-operative with the preoperative personality.

We believe that at this juncture a small group of intensively studied patients might add more to our knowledge than more less critically studied patients. The need at present is for an understanding of the actual processes involved in the psychotic episode and their exact alteration after lobotomy is performed. To accomplish this it would seem that the critical study by methods of introspective and analytic psychometric means both before and after lobotomy would be illuminating.

Finally, little has been said in the foregoing regarding to just what diagnostic group this operative treatment or its parallel "conservative" treatment is to be applied. This omission is justifiable because this procedure has shown that it obtains its best results on that group of patients featuring severe depressive phenomena, or as has been stated, those psychoses which have their origin in an acute and painful consciousness of the self regardless of the nosologic department to which they may be arbitrarily assigned.

The criticism that the surgical procedure under discussion produces an irreversible condition is invalidated if the condition produced is favorable to the patient. The number of cases treated has not been sufficient to fully establish the merit or lack of merit of prefrontal lobotomy nor has it been submitted to the acid test of time that will determine its value, but from present indications it has sufficient merit to justify farther trial in cases where a reversal of personality trends can be reasonably anticipated as beneficial to the total mental status of patients with refractory depressive psychoses.

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DECONTAMINATION OF EYES AFTER EXPOSURE TO LEWISITE AND MUSTARD

Since publication of the Office of Civilian Defense handbooks, "First Aid in the Prevention and Treatment of Chemical Casualties" and "Protection Against Gas," further experience has shown that the two per cent solution of hydrogen peroxide recommended for the treatment of eyes following Lewisite burns may be injurious if used undiluted. The Chemical Warfare Service now recommends a single instillation in the eyes of 0.5 per cent solution of hydrogen peroxide as soon as possible after contamination with Lewisite. This solution may be prepared by diluting one part of a two per cent solution with three parts of water, or one part of a three per cent solution with five parts of water. The solution usually found in drugstores is the U. S. P. strength of 2.5 to 3.5 per cent hydrogen peroxide. A 0.5 per cent solution of potassium permanganate has also been found effective as an eye instillation following exposure to Lewisite.

In planning decontamination stations, the Medical Division, Office of Civilian Defense, recommends that provision be made near the entrance of the second or shower room for the irrigation of the eyes of contaminated persons. The schematic sketch of a decontamination station in the Office of Civilian Defense publications mentioned above shows the irrigation of eyes in the dressing room, whereas this should be carried out in the second or shower room before the bath is given. Delay until the casualty reaches the dressing room will result in more serious injury to eyes which have been contaminated with mustard or Lewisite.

WAR RATIO OF MALE TO FEMALE BIRTHS

The normal proportion of male births over female births was even greater in every European belligerent power during the last years of World War I and for perhaps two or three years afterward, *The Journal of the American Medical Association* for November 22 says in answer to an inquiry.

"The proportion of male births increased also in many of the important European neutral countries," *The Journal* continues, "including Norway, Sweden, the Netherlands and (for the year 1920) Switzerland. There was an observable rise in Australia, but not in the United States or in New Zealand, among the non-European belligerents. The increase in the proportion of male births, where observed, was of short duration."

As for the reasons for this increase, *The Journal* says, "A simple explanation that seems entirely adequate has not yet been offered."

RUPTURED EXTRAUTERINE PREGNANCY

Letteer Lewis, M.D.

McPherson, Kansas

A white woman age forty was first seen in her home on February 26, 1942. She stated that while getting ready to take a bath she had spilled water on the bathroom floor, and had stooped over to mop up the water when she was seized with a severe pain across her entire lower abdomen. The pain was very severe and seemed to spread in waves up her abdomen. She began to feel faint so she went to bed. In a few minutes she felt even more faint and tried to arise and call a doctor, but found that she was too weak, so she called to a lady living in her house and had her notify the doctor.

CASE REPORT

Examination revealed a white, blond, obese female about forty years of age lying in bed in shock. She had profuse diaphoresis, was pulseless at the wrist, was cyanotic, and had rigidity of the entire lower abdomen. Her temperature was 99.6, pulse was 160 and her respiration was thirty-six. Questioning revealed that her last menstrual period had been nearly two months previous on December 30, 1941, but she attributed this fact to her age and thought that she was starting into the menopause. Pelvic examination revealed a moderately enlarged uterus with extreme pelvic tenderness, so that a more complete examination could not be obtained.

With this history and findings a diagnosis of ruptured ectopic pregnancy was made, and the patient sent to the hospital via ambulance for immediate surgical intervention.

The patient arrived at the hospital at 12:30 noon in a much improved condition. The temperature was 99.6, pulse sixty and respiration thirty. Blood pressure was 110/75. She stated that a sense of fullness in the lower abdomen was her only symptom. Further history at that time revealed that the patient had had a uterine suspension eight years previous and that both tubes had been ligated at this operation, and further that she had been having intercourse without any contraceptives during these eight years without pregnancy.

At 3:45 p. m. the patient's temperature was 97, pulse was eighty and the respiration was twenty-four. The R. B. C. was 3,340,000, W. B. C. 25,000 with eighty-four per cent polymorphonuclear leukocytes, and sixteen per cent lymphocytes. The hemoglobin was sixty-eight per cent.

Due to the rapid disappearance of symptoms, and the relatively high white blood count, which we felt was higher than the usual hemorrhage case, operation was postponed. The patient remained in the hospital for five days where she became entirely symptom free. A pelvic infection was considered, although a smear revealed no unusual organisms. At the time of dismissal a pelvic examination revealed a moderately enlarged uterus with a firm somewhat tender mass in the left adnexa. At no time during her stay in the hospital did the patient have a discharge of any kind. An Aschheim-Zondek pregnancy test was not done.

During the next few days the patient was up and about

her duties. She flowed some dark blood on two occasions, one time it was quite profuse after she had taken a trip out of town about fifty miles distant.

On March 23, 1942, nearly four weeks after the initial symptom it was decided that surgery was in order. Under spinal anesthesia the abdomen was opened in the mid-line. The omentum had formed a plug superiorly so that a pocket of blood was held in between the uterus in the mid-line, the broad ligament posteriorly, and the anterior abdominal anteriorly. About 500 c.c. of old blood was removed and the ruptured tube ligated and removed. The patient had an uneventful recovery and was dismissed from the hospital in ten days.

The pathological report: "Sections from this material show a very extensive hemorrhage with areas of necrosis and numerous chorionic villi." Diagnosis: "Ruptured ectopic tubal pregnancy."

Pathologically extra uterine or ectopic pregnancy may be divided into several classes:

- (1) Before rupture.
- (2) Intraperitoneal rupture with profuse hemorrhage. This is the type of which one usually hears where the blood pours out into the peritoneal cavity rapidly and in great quantity.
- (3) Intraperitoneal rupture with repeated moderate hemorrhage. In these cases the membranes often remain partially attached within the broken tube, and hence the extruded embryo continues to grow, causing further rupture of the tube with accompanying fresh intraperitoneal hemorrhage of small or large amount. This process may be repeated many times within the course of a few months, provided the patient does not succumb to hemorrhage or peritonitis.
- (4) Intraperitoneal rupture with single moderate hemorrhage. In these cases the blood gravitates into the culdesac of Douglas where adhesions bind together the structures above, thus forming a roof which shuts off the blood-filled culdesac from the remaining part of the peritoneal cavity.
- (5) Tubal abortion: Here the embryo with its membranes is extruded from the end of the tube into the peritoneal cavity. The symptoms in these cases are the same as tubal rupture only they are usually less severe.
- (6) Rupture into broad ligament: This of course forms a hemotoma in the broad ligament.
- (7) Interstitial pregnancy: In this type of pregnancy the ovum lodges and develops in the interstitial portion of the tube, so that development takes place within the wall of the uterus, although it is outside the uterine cavity.
- (8) Ovarian pregnancy.
- (9) Wandering pregnancy is the name attached to a pregnancy found in the peritoneal cavity without any apparent connection with the tubes, uterus or ovary.

- (10) Extrauterine pregnancy carried to near term.
- (11) Bilateral tubal pregnancy.

SPECIAL SYMPTOMS

The special symptoms of ectopic pregnancy are: (1) Missed menstruation; (2) Sudden onset of pain in the pelvis severe enough to confine her to bed and may cause complete prostration and collapse. (3) Bloody vaginal discharge. (4) A tender mass in the adnexal area. (5) Only slight temperature. (6) Evidence of internal hemorrhage. (7) Exacerbations of pain without apparent cause and without decided elevation of temperature. (8) Some of the early signs of pregnancy may be present. (9) Positive Aschheim-Zondek pregnancy test. (10) Absence of intrauterine pregnancy.

The patient reported seemed unusual in her very rapid recovery from the original ruptured ectopic tubal pregnancy symptoms, and in the fact that she had no vaginal discharge of blood during her original visit to the hospital. It also seems unusual that the patient should have intercourse for eight years without the use of contraceptives and not become pregnant, and then finally become pregnant.

THE NATIONAL HEALTH

"A lot of draftees have been rejected because of minor physical defects, so the compulsory repair of as many of them as possible has been ordered. This is all to the good, we think—one of the numerous ways in which the draft can be made to work widespread benefits.

However, when the politicians go on to talk about a national health program to include practically all of us, it sounds to us like hashish. Americans are too fond of gypping such government ukases, as was proved for all times, we thought, by the prohibition experience.

We think the national health can best be improved in the ways in which it has been improved for the last thirty-five or forty years. We mean chiefly by individual efforts and health study—don't eat too much; don't eat crazy food combinations; see your dentist at least twice a year; take reasonable exercise; be moderate with your liquor, tobacco and other indulgences; act your age; get a full physical checkup once a year from a reliable doctor; above all, don't worry too much about your health.

These individual efforts should be supplemented by prudently managed group hospital insurance plans, more and more community attention to hospital services, sanitation, parks and playgrounds, care of school children's teeth, free school lunches of milk, the spreading of infection and cure, and so on.

In short, we think the national health is doing all right.

And speaking of the draft army, a lot of the boys are learning things they never suspected before about sensible foods and food combinations. As they steam back to civil life, the demand for fruits, fruit juices, vegetables and other health foods ought to soar—which in itself will be an automatic boost to the national health".—Collier's, November 29, 1941.

ACUTE PERFORATED PEPTIC ULCER *

Frank Foncannon, M.D.

Emporia, Kansas

This is a review from 1923-1940 of that most dramatic of acute abdominal catastrophies, perforated gastric and duodenal ulcer. These cases occurred in Newman Memorial and St. Mary's Hospitals of this city.

This is predominantly a disease of men. Comparatively few cases in women are recorded, Eliason and Ebeling⁷ reporting as low as 3.2 per cent. The reason for this preponderance in males is unexplained. In this series thirty-two were in males and two in females or 5.8 per cent.

While it is commonly taught that symptoms of peptic ulcer are more marked in spring and fall a review of reports of various large clinics vary greatly as to seasonal influence. In this series the majority occurred in the summer months followed by spring, fall and winter. (Fig. 1.)

Fig. 1.

Season	Number	Per Cent
Spring	9	26.4
Summer	14	41.1
Fall	7	20.5
Winter	4	11.8

Most cases occur between the third and sixth decades. However, it often occurs in the aged and Quinn⁶ reports three cases in the newborn, all fatal and proved by autopsy. Others have reported cases in children seven, twelve, and fourteen years, respectively. The oldest patient in this series was eighty-three and the youngest twenty-one with an average of fifty-one. (Fig. 2.)

Fig. 2.

Age Years	Number Perforations	Per Cent
1-10	0	0
17-20	0	0
21-30	1	2.9
31-40	5	14.7
41-50	9	26.4
51-60	4	11.8
61-70	11	32.3
71-80	3	8.8
81-90	1	2.9

PREVIOUS HISTORY

One cannot attach too much importance to the history. True a majority will give a suggestive ulcer history, others one of slight digestive disturbance and

* Presented at a meeting of the Lyon County Medical Society, October 29, 1941.

in some the perforation is the first sign of the disease. Many give a history of having ulcer treatment which may or may not prove anything. In this series those with a long history of indigestion are considered as having an ulcer history, those with little or no previous symptoms as negative. (Fig. 3.)

Fig. 3.

ULCER HISTORY

	Number	Per Cent
Suggestive or definite	29	85.2
None	5	14.8

CAUSE OF PERFORATION

Possible causes of perforation given in the literature are over distention with food, alcohol, physical exertion, trauma and foci of infection.

There has of late been considerable attention given to the nutritive condition of the patient. This has a bearing not only on the healing of the ulcer but also upon the operative wound which is prone to disrupt or become infected.¹⁷ It is felt that the same factors that cause the healing difficulty in the wound may also cause the perforation, i.e. nutritive disturbances such as vitamin C and serum protein deficiencies.

PHYSICAL FINDINGS AND SYMPTOMS

The classical symptoms have been so well described in text books as to be almost standardized. So much so in fact that a case with atypical signs is often denied surgery until the safest period (i.e. six or eight hours) has passed.

The leading clinics report a correct preoperative diagnosis of seventy to eighty per cent. Twenty to thirty per cent either are operated upon under some other diagnosis or as an acute abdomen. Some are not recognized until they reach the autopsy table. Undoubtedly some recover without operation. In fact Nagle⁵ reports a recovery with gastric syphonage alone.

The typical case gives a history of terrific epigastric pain, sudden in onset and often radiating to the shoulder. The face is drawn, pale and covered with perspiration. The abdomen has a board-like rigidity. The pain is constant in its intensity and is only partially relieved by morphine. One symptom that is almost pathognomonic is the expiratory grunt. In breathing the patient moves the irritated diaphragm, causing pain and exhales with a grunt.

Dickinson¹⁹ speaks of subacute perforation in ulcer patients in which the symptoms are much milder and is often thought to be an increased activity of the ulcer. There is vomiting with pain and tenderness in the epigastrium. This often disappears in a few hours and the patient goes on to spontaneous recovery in a few days. These cases have been proved by finding free gas in the peritoneal

cavity by x-ray. Singer and Vaughn²⁰ feel that they are as frequent as acute perforation. The problem is to decide whether or not they have closed spontaneously. The safest plan is to operate in the first twenty-four hours unless the process is apparently quiescent.

The statement that a bleeding ulcer will not perforate and a perforating ulcer will not bleed does not hold true and Winters and Egan²¹ state that bleeding occurred in ten per cent of cases in Cook County Hospital in the years 1935-1938.

ATYPICAL SIGNS AND SYMPTOMS

As stated before most clinics report seventy to eighty per cent correct diagnosis. The remaining twenty to thirty per cent which are operated under some other diagnosis are worthy of consideration. The distortion of the symptoms can be due to several factors. The position of the ulcer according to Mooney²³ has to do with the radiation and character of the pain. These anterior and near the pylorus give the classical symptoms. There the spillage is directed by the duodenum, omentum and other structures over the abdomen and down to the sensitive anterior abdominal wall. Ulcers on the anterior superior surface of the duodenum often drain into the right gutter.

Those situated on the posterior wall of the stomach will rupture into the lesser sac, drain down through the foramen of Winslow and give colicky pain as in acute intestinal obstruction. On the greater curvature the symptoms are more likely to be confined to the left quadrant.

The tendency of the fluid to gravitate downward will produce tenderness in the area it traverses. Thus it is that low abdominal incisions are sometimes made. In one such case I found upon vaginal examination extreme tenderness on manipulation of the uterus. Nearly always in these cases there is a history of sharp epigastric pain several days before, which subsides after a few hours then becomes worse.

X-RAY DIAGNOSIS

Most writers claim that air can be demonstrated under the diaphragm in seventy-five to eighty per cent of cases. They also have maintained that it was essential that the patient be in the upright position. However, this position holds a real danger for the patient. Since a majority of ulcers are near the pylorus, with the patient standing the perforation is at the most dependent part and fluid will escape more easily increasing the possibility of peritonitis or abscess. However, if the patient is placed on the left side the stomach contents will gravitate towards the fundus lessening the escape of fluid and allowing air to escape through the perforation. The patient may be x-rayed in this position and the gas

demonstrated between the liver and lateral abdominal wall.¹⁸ Quoting from Moynihan, Eustermen and Bal-four⁹ give this description of a patient with perforated ulcer, "The agony suffered by the patient is beyond belief—what strikes every onlooker is that the patients body is rigid and motionless, no slightest movement dare be attempted." Therefore, placing a patient in the upright position is an unnecessary hardship when more can be accomplished in the left lateral decubitus position.

LABORATORY FINDINGS

One may expect to find a rapid rise in the white count in most cases. In this group the white count ranged from 5,600 to 39,600 with an average of 18,000. The total polynuclear count varies from a low of sixty-four to a high of ninety-six and averaged eighty-five plus. (Fig. 4.)

Fig. 4.

LEUCOCYTOSIS

W. B. C.	Number of Patients	Per Cent
Under 8,000	1	2.9
8,000-10,000	1	2.9
10,000-12,000	4	11.7
12,000-15,000	8	23.5
15,000-20,000	11	32.3
Over 20,000	9	26.4

ANESTHETIC

Carver¹⁰ feels that general anesthetic is superior to spinal in that the tendency to excessive retching when the stomach is manipulated is avoided. On the other hand Graham¹ feels that, "the extreme respiratory effort which accompanies inhalation anesthesia produces a plunger action of the liver through movement of the diaphragm; thus greatly accelerating the dissemination of the duodenal contents throughout the peritoneal cavity." Twenty-nine of this series were done under general anesthesia. Four received spinal and one local anesthetic. (Fig. 5.)

Fig. 5.

ANESTHETICS

	Number
Ether	29
Spinal	4
Local	1

PREOPERATIVE TREATMENT

Operation should be as soon as possible after diagnosis is made. The time interval between the perforation and the surgical closure of the ulcer may determine the patients recovery as the mortality rate rises rapidly with each succeeding hour after the first six hours.¹⁵ Despite this fact Graham¹ has prolonged the time interval in some cases for as long as eight hours in order to treat the shock and pain and to restore fluid balance.

As Ravdin¹⁶ has pointed out, time alone is not all important but rather what is happening during the time from perforation to operation. The patient who drinks large quantities of water and retches a great deal will have more spillage than one who lies quietly and has an empty stomach at time of perforation.

It is well to empty the stomach with a Levine tube but this is often difficult because of food particles that obstruct the lumen of the tube. No attempt should be made to wash the stomach as this will only increase the spillage. The chief object should be to keep the patient quite, the stomach empty and restore the balance of fluid and salt.

TREATMENT

In reviewing recent literature there is difference of opinion as to procedure, i.e. simple closure or resection—to drain or not to drain. Most men in this country subscribe to simple closure while in Europe—mostly Germany and Russia,⁴ they resect.

Of late years many surgeons feel that drainage is not necessary but this is not universally accepted by any means. Some feel that drainage is not necessary in the absence of localized abscess formation.

Shipley¹¹ states that "there is much clinical evidence that drains left in the peritoneal cavity are soon sealed off, and there is abundant proof that the peritoneum is a very efficient tissue in taking care of its own difficulties."

In a survey made by Trout¹² of more than 100 surgeons about eighty per cent closed the abdomen without drainage. Personally I have drained most of my cases and also at the time of operation aspirated as much of the spillage as possible from the peritoneal cavity including the pelvis and the anatomical gutters.

OPERATION

If possible I use a purse string suture of silk or chromic gut. However, as many of you have probably observed this is impossible in the majority of cases because of the induration and friable nature of the tissue surrounding the perforation. In these cases I use either a figure of eight or interrupted sutures. Over this is sutured a piece of omentum either attached or free. As Graham¹ has pointed out the omentum provides the scaffolding and the stimulus for the formation of fibrin which produces the final closure. Obviously this is a simple procedure. No exploration is done. None should be done. This operation is a life saving measure and any further procedure would be meddlesome surgery.

It has been often stated that once an ulcer perforates and the patient recovers there are no further symptoms. This does not always obtain, many cases of a second perforation having been reported. There

is one such case in this series. Repeated perforation of peptic ulcer occurred in four per cent of 300 cases reviewed by Cohn.²² Bryce¹³ states that any return in symptoms after a simple closure will take place in two years. This was based on a survey of forty-eight cases in whom recurrence of symptoms took place. Kelly¹⁴ found in a follow up of fifty-seven cases 75.4 per cent had good results, 17.5 per cent a fair result and seven per cent poor results.

LOCATION

Thompson⁸ reports sixty-nine per cent on anterior wall of stomach or duodenum. This series shows eighty-five per cent on the anterior or anterior superior surface with the majority at or near the pylorus. There were thirty gastric and four duodenal ulcers. Posterior ulcers tend to become fixed to and penetrate into the substance of nearby organs or structures. Multiple ulcers with perforation occur but they are rare and did not occur in this series.

POST OPERATIVE TREATMENT

Continuous decompression following the operation, with the Levine tube is established and continued for three or four days until danger of peritonitis has passed. Fluid and salt balance is maintained subcutaneously or intravenously. Adrenal cortex is of value to help the patient retain his sodium and potassium balance. After a few days one may begin the regular ulcer therapy and diet that best suits the patient.

RESULTS

Of thirty-four patients in this series four died or 11.7 per cent. This, I think, argues well for the simple closure as it is much lower than many series in which more extensive procedures were used. (Fig. 6.)

Fig. 6.

RESULTS

	Number	Per Cent
Recovery	30	88.3
Died	4	11.7

NOTE

Since this paper was written I have operated upon another case which developed an unusual complication. The usual simple closure was used. One month later complete obstruction of the pylorus developed evidently from the scar tissue formed by the ulcer. Posterior gastro-enterostomy was done. This relieved the condition and the patient is back at work.

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URINALYSIS BEFORE APPENDECTOMY

Maurice A. Walker, M.D.

Kansas City, Kansas

The requirement by hospitals of certain laboratory tests preliminary to surgical operations should not be absolute. The value of any information to be obtained from examination of the urine specimen of young adult males with acute appendicitis is outweighed by the dangers that may follow catheterization. Diabetic acidosis, which may simulate appendicitis, should be suspected from a careful history and physical examination. Albuminuria without other signs of renal disease does not contraindicate the removal of an acutely inflamed appendix. Conditions causing pyuria and hematuria in young males are rare without other suggestive symptoms and signs.

REPORT OF CASE

A man, aged twenty, began to have cramping distress in the epigastrium and around the umbilicus. The pain moved toward the right side after six hours. When admitted to the hospital twenty hours later the right lower quadrant of the abdomen was quite tender. In each cc. of blood there were 18,500 leukocytes, eighty-four per cent of which were polymorphonuclears. Since he could not promptly void a urine specimen for routine examination he was catheterized by an orderly at the instruction of the nurse supervisor. Apparently some difficulty was encountered although eventually a urine specimen was obtained which did not contain albumin or sugar but did contain some blood.

A gangrenous appendix was removed about two hours after he was admitted to the hospital. Thereafter he was not able to void. Catheterization was necessary every eight hours for the succeeding six days. About thirty-six hours following operation, after he had been catheterized several times, he had a chill. He ran a septic course for a week. His wound healed normally. There was urethral discharge in which no specific bacteria could be found. Apparently the entire cause of his stormy convalescence was infection of the urinary tract, undoubtedly inaugurated by the trauma of the initial preoperative catheterization.

President's Page

To the Members of The Kansas Medical Society:

Our Society is closing a year of fine work, and to Dr. Blake, our retiring President, I wish to extend congratulations on his very successful administration of the affairs of our Society. I shall be well satisfied, indeed, if I am able to do as well in the year ahead as he has done in the year just past.

Due to the war work, the primary election, the November election, and the meeting of the Legislature, the year ahead must of necessity be a full year with much work for all of the members, committee members, and officers of our Society. The war needs and the civilian needs must both be met.

Many of our members will be in military service, giving their all to the country's needs; many of our members will remain at home to meet the civilian needs—to those who remain at home, falls the duty of guarding and further developing the position of medicine, and this can be accomplished only by continuing actively the work of our Society. This means that active committee work remains more than ever a necessity. Certain desirable but not immediately essential committee projects may have to be held in abeyance, but it is important that all essential committee work be continued.

To our country our Society pledges its full cooperation in meeting the war needs.

To the public our Society pledges its full efforts and long hours of work by all to give adequate medical care both to the people at home and to the armed forces.

To our members in military service the members who remain at home pledge themselves to the continued upbuilding of the position of medicine.

To The Kansas Medical Society I pledge myself and the Society officers to the carrying out of the Society work to the best of our ability.

Sincerely yours,

Henry W. Tichen, M. D.

President, The Kansas Medical Society.

EDITORIAL

PRESIDENT-ELECT

The Society welcomes Dr. John L. Lattimore of Topeka, as its President-Elect for 1942-43, and as its President for 1943-44.

Dr. Lattimore is particularly experienced and acquainted with the work of the Society in that he served as its First Vice-President during the year 1941-42; as Councilor of the Fourth District for the maximum permitted of two consecutive terms; as a member of many of its committees and as he has assisted and taken part in numerous other functions of the organization. He has also been a member of the Kansas State Board of Health for many years; he is a member of the Board of Directors of the newly organized Kansas Group Hospital Service; and he is active in many other medical and lay organizations. Likewise, he served as President of the American Society of Clinical Pathologists in 1941-42. This experience coupled with his general medical and executive ability well equip him to accept the important responsibility of his office.

The Society has, in its election of Dr. Lattimore, made a worthy addition to its long line of capable and efficient Presidents.

ANNUAL MEETING

The 83rd Annual Meeting of the Society held in Wichita from May 11 to May 14 was very successful in every respect. As a matter of fact the Sedgwick County Medical Society and the other host societies which assisted are deserving of great praise for their ability to provide a meeting of the kind they provided under present circumstances. From the beginning of their plans for the meeting to its conclusion they were confronted with many difficult problems pertaining to the completion of the arrangements.

The meeting was one of the best conducted and the best in appearance the Society has ever had. The program was complete and practical and many favorable comments were heard about its excellence. The annual banquet at which the dance was played by Ted Fio Rito's orchestra, was certainly one of the best in the history of the Society and it probably was one of the best any medical organization has ever presented. Likewise, the stag banquet with a program presented by professional talent and a very interest-

ing theme and toast-master was as good as entertainment can be. General attendance was somewhat smaller than usual but the registration of 754 at the meeting is undoubtedly very favorable under war conditions. The events for ladies were complete, well arranged, and well attended. The same is true of the meetings of the Kansas Obstetrical Society, the Kansas Heart Association, the Kansas Medical Golf and Trapshooting Association, and the Kansas Medical Assistants Society. The scientific exhibits were numerous, complete, interesting and were presented in excellent arrangement.

The technical exhibits at the meeting were as follows:

Meade Johnson & Company, Evansville, Indiana.
 Phillip Morris & Company, Ltd., New York, New York.
 The Borden Company, New York, New York.
 The W. E. Isle Company, Kansas City, Missouri.
 American Optical Company, Kansas City, Missouri.
 The Mennen Company, Newark, New Jersey.
 Abbot Laboratories, North Chicago, Illinois.
 The Mid-West Surgical Supply Company, Inc., Wichita, Kansas.
 Holland-Rantos Company, Inc., New York, New York.
 Smith, Kline & French Laboratories, Philadelphia, Pennsylvania.
 Parke, Davis & Company, Detroit, Michigan.
 Pet Milk Sales Corporation, St. Louis, Missouri.
 The Medical Protective Company, Fort Wayne, Indiana.
 S. H. Camp & Company, Jackson, Michigan.
 Greb X-Ray Company, Kansas City, Missouri.
 Cerophyl Laboratories, Inc., Kansas City, Missouri.
 H. G. Fischer & Company, Chicago, Illinois.
 M. & R. Dietetic Laboratories, Inc., Columbus, Ohio.
 Gerber Products Company, Fremont, Michigan.
 Petrogalar Laboratories, Inc., Chicago, Illinois.
 Burroughs Wellcome & Company (U.S.A.), Inc., New York, New York.
 C. B. Fleet Company, Inc., St. Louis, Missouri.
 E. R. Squibb & Sons, New York, New York.
 General Electric X-Ray Corporation, Kansas City, Missouri.
 A. J. Griner Company, Kansas City, Missouri.
 William S. Merrell Company, Cincinnati, Ohio.
 Dairy Council of Wichita, Wichita, Kansas.
 American Hospital Supply Corporation, Chicago-New York.
 Quinton-Duffens Optical Company, Topeka, Kansas.
 Camel Cigarettes, New York, New York.
 Ortho Products, Inc., Linden, New Jersey.
 Archer-Taylor Drug Company, Wichita, Kansas.
 Riggs Optical Company, Kansas City, Missouri.
 A. S. Aloe Company, St. Louis, Missouri.
 John Wyeth & Brothers, Inc., Philadelphia, Pennsylvania.
 Carnes Artificial Limb Corporation, Kansas City, Missouri.
 J. R. Siebrandt Manufacturing Company, Kansas City, Missouri.
 Davis & Geck, Inc., Brooklyn, New York.
 Eli Lilly & Company, Indianapolis, Indiana.
 The Society appreciates very much the generous support these exhibitors gave to the meeting.

The new Officers and Councilors elected at the meeting were as follows: President-Elect, Dr. John L. Lattimore of Topeka; First Vice-President, Dr. Marion Trueheart of Sterling; Second Vice-President, Dr. W. P. Callahan of Wichita; Secretary, Dr. F. R. Croson of Clay Center; Treasurer, Dr. Geo. M. Gray of Kansas City; Councilor for the First District, Dr. J. W. Randell of Marysville; Councilor for the Second District, Dr. O. W. Davidson of Kansas City; Councilor for the Seventh District, Dr. Russell R. Cave of Manhattan and Councilor for the Eighth District, Dr. Ben H. Mayer of Ellsworth. Dr. Henry N. Tihen of Wichita was installed as the new President for 1942-43.

The Kansas Medical Society takes pride in the fact that it has one of the best meetings in the country and the Sedgwick County Medical Society and its assisting hosts may also take pride in the fact that they have continued and furthered this record in a very difficult year.

CORRECTION: In the editorial "Plasma" published in the March issue of the Journal, page 108, the following correction is to be made in the next to the last paragraph, second line, to read as follows: "Liquid plasma is simply kept at four (not forty) C until ready for use."

MEDICAL SCHOOL

THE UNIVERSITY OF KANSAS SCHOOL OF MEDICINE

Kansas City, Kansas

ACCELERATED MEDICAL SCHOOL PROGRAM

The great demand for physicians in the country's armed forces has long been in the minds of the field of medical education and in conformance with the recommendations of the Association of American medical colleges, most all schools in the United States have adopted some form of an accelerated medical curriculum.

The University of Kansas School of Medicine will institute such a program this year. This decision was recently adopted by the Administrative Committee of the School of Medicine and will enable the students entering the freshman class in June 1942 to graduate in June 1945. Acceleration in all other classes will begin in the fall and is being arranged to conform with this program.

Acceleration of the medical curriculum does not mean that the standards of medical education are to be lowered or that courses are condensed, curtailed or abbreviated. Instead, acceleration means only that vacation periods be shortened, especially the long summer vacation, but not to a degree which will not

give the student sufficient surcease from study since that may seriously endanger his health.

Increased clinical facilities to accommodate the "speed up" are being arranged with local hospitals already affiliated with the School of Medicine.

A program of continuous medical education will handicap many students from financial strain and it is hoped that these students will be able to receive some financial assistance from prospective new loan funds and from the federal government through the United States office of Education Wartime Commission.

FACULTY

The faculty of the school of Medicine has also been greatly affected by the national wartime effort. The following members having been called to active military duty:

Berry, Max	U. S. Army
Bills, M. L.	U. S. Navy
Coburn, D. F.	U. S. Navy
Campbell, J. W.	U. S. Army
Erni, H. E.	U. S. Navy
Ellis, Ralph	U. S. Army
Etzenhouser, Merrill	U. S. Navy
Frick, Paul	U. S. Navy
Gripkey, C. A.	U. S. Navy
Jarvis, James	U. S. Navy
Lowry, Charles F.	U. S. Army
Millett, Henry S.	U. S. Navy
Newman, R. L.	U. S. Army
Nothnagel, A. F.	U. S. Army
Pendleton, R. L.	U. S. Army
Robinson, G. W., Jr.	U. S. Navy
Ryan, M. J.	U. S. Navy
Schutz, R. B.	U. S. Navy
Ziegler, A. M.	U. S. Navy

The 77th Evacuation Hospital, the University of Kansas School of Medicine Unit, has received their alert warning and were called to active duty in May. This unit lists thirty-three physicians of the school faculty and fifty-two graduate nurses.

NEWS

The Medical School, during the past year, has had the privilege of hearing special lectures from the following visitors:

Dr. C. A. Mills, Prof. of Experimental Medicine, College of Medicine, University of Cincinnati, Cincinnati, Ohio.

Dr. Thomas Francis, Jr., Professor of Epidemiology, University of Michigan, Ann Arbor, Michigan.

Dr. Chauncey D. Leake, Professor of Pharmacology, School of Medicine, University of California, San Francisco, California.

Dr. Armond Quick, Assistant Professor of Pharmacology, Marquette University, Milwaukee, Wisconsin.

OFFICIAL PROCEEDINGS

FIRST SESSION OF THE HOUSE OF DELEGATES

The first regular session of the House of Delegates was held at the Hotel Allis in Wichita on Tuesday, May 12, 1942, commencing at 9:30 p.m. Dr. C. D. Blake, President, presided and called the meeting to order.

Dr. Blake asked Dr. A. W. Fegtly of Wichita, Chairman of the Committee on Constitution and By-Laws to explain the method of registering and seating delegates, which he did.

Dr. Fegtly was appointed sergeant-at-arms of the House of Delegates.

Upon a motion by Dr. O. W. Davidson of Kansas City, seconded and carried, the report of the Committee on Credentials, the roll call of delegates, and the reading of the minutes were dispensed with.

Dr. Blake described the procedure governing the reading and adoption of the reports of the Reference Committees.

Dr. Blake announced that the following Reference Committees had been appointed:

Reference Committee for Reports of Officers and Councilors: J. J. Brownlee, M.D., Hutchinson, Chairman; Earl F. Clark, M.D., Belle Plaine.

Reference Committee for Reports of Committees and Resolutions: Philip W. Morgan, M.D., Emporia, Chairman; C. E. Joss, M.D., Topeka; C. K. Schaffer, M.D., Topeka; C. W. Erickson, M.D., Pittsburg.

Dr. Blake also announced that the Reference Committees had met during the day and considered the various annual reports and that the Reference Committees were ready to present their comments and recommendations thereon to the House of Delegates.

Dr. Brownlee presented the following report on behalf of the Reference Committee on Reports of Officers and Councilors:

TO: THE HOUSE OF DELEGATES

"The Reference Committee on Reports of Officers and Councilors has met and considered the following reports:

"The report of the Treasurer was read and it was found that the finances of the Society are in good condition. Dr. Geo. M. Gray, the Treasurer, is here and will present his report to the House of Delegates.

Dr. Gray then read the following report:

TREASURER'S REPORT—MAY 11, 1942

Balance on hand in the Riverview State Bank, Kansas City, Kansas, May 5, 1941.....\$10,667.58
Received from Merchants National Bank, Topeka, Kansas, December 30, 1941.....\$ 2,855.00

Received from Merchants National Bank, Topeka, Kansas, February 24, 1942..... 6,420.00
Received from Merchants National Bank, Topeka, Kansas, May 1, 1942..... 11,637.50
Received from Merchants National Bank, Topeka, Kansas, May 8, 1942..... 828.75
Received from Merchants National Bank, Topeka, Kansas, May 9, 1942..... 255.00

Total Receipts 21,996.25

\$32,663.83

Expended during the year from the General Fund.....\$15,602.72
Expended during the year from the Defense Fund..... 1,689.14

Total Expenditures 17,291.86

Balance in Riverview State Bank, Kansas City, Kansas, on May 11, 1942..... \$15,371.97

Your balance in the Riverview State Bank, Kansas City, Kansas on May 11, 1942, is \$15,371.97 which is \$4,704.39 more than we had on last May 5, 1941, and no debts. You also have in my hands United States Savings Bonds with a cash value today of \$8,400.00 which will mature February 1, 1947, at which time they will have a value of \$10,000.00.

We must expect some falling off in our income from dues as our members enlist in the war service, and there will be more each year as long as this war continues, so we may expect our income to decline each year, and I think the Society should be operated within our income if a little more economy is practiced. I have listed or grouped the larger expenditures for the past year hoping that it may be of assistance in determining where some saving can be made without disturbing the normal functions of the Society. While the surplus in our Journal fund is some what reduced this year on account of the purchase of supplies, yet it is on a self supporting basis and I think should give us no cause to worry. The vouchers both in the Journal account and the defense and general accounts are in my hands.

Dr. Gray commented on his report stating that the Society now has the best financial position it has had in many years, but that by reason of the war and reduced future income from dues thereby, it should in his opinion, inaugurate and accomplish all economies possible.

Dr. Brownlee then continued as follows with the report of his Committee:

"Dr. John Porter, Concordia, the Secretary of the Society, is engaged in military service, and has resigned his office. No report for the Secretary was, therefore, received by the Reference Committee.

"The report of the Editorial Board will be made by Dr. W. M. Mills of Topeka, the Chairman of that Board."

Dr. Mills then read the following report:

TO: THE HOUSE OF DELEGATES:

The financial statement for the Journal shows all income and expense to and including the April, 1942, issue and reflects the following condition:

FINANCIAL REPORT OF THE JOURNAL OF THE
KANSAS MEDICAL SOCIETY

May 1, 1941, to May 1, 1942

Cash in Bank.....	\$ 981.49	
ASSETS:		
Accounts Receivable		
April Adv. Rec.	\$575.68	
Other Acc. Rec.	181.00	
		756.68
Paper Stock on Hand.....		417.82
Stamps and Mailing Fund Deposit..		35.00
		<u>502.82</u>
	\$2,190.99	\$2,190.99
LIABILITIES:		
Accounts payable		
April engraving	\$ 45.00	
April printing	379.03	
		<u>424.03</u>
Surplus		\$1,766.96

INCOME AND EXPENSE REPORT

INCOME:		
Advertising	\$5,831.91	
Subscription and Miscellaneous	60.29	
		<u>\$5,892.20</u>
EXPENSE:		
Printing	\$2,869.14	
Engraving	176.76	
Mailing and Postage.....	290.00	
Salary	1,287.00	
Paper Stock	931.19	
Miscellaneous	80.23	
		<u>5,634.32</u>
Net surplus for year.....	\$ 257.88	

The amount of \$257.88 shown is in excess of income over expense for 1942 may be compared with the amount of \$133.34 shown as excess of income over expense for 1941. Likewise, the surplus of \$1,766.96 for 1942 can be compared with the surplus of \$1,582.18 for 1941.

The Journal income was \$5,892.20 in 1942 as compared with \$5,829.58 in 1941 and as compared with the years previous some increase in expense is shown due to the purchase of a better grade of paper stock used in the Journal in the last two years, which it is hoped have materially improved the appearance of the publication.

The Journal pays its own expenses in all matters of supplies, postage, salary of its full time employee, paper, printing and mailing of the Journal.

The Journal appeared on January, 1942, with a new cover design. The regular sections have been continued throughout the year and the material for the medical school section has been contributed by the University of Kansas School of Medicine.

The Journal has continued its former policy of contributing all exchange publications to the Library of the University of Kansas School of Medicine, these number some 150 per month. A small advertisement is printed in the Journal advising members of library facilities. Books received for review in the Journal

office are sent to the Stormont Medical Library and in the past year these number some sixty volumes.

Two members of the Editorial Board are at the present time serving in the armed forces. Captain Don C. Wakeman is in the Army and Lieutenant Commander L. R. Pyle is in the Navy.

The Editorial Board is of the belief that a larger number of papers can be prepared by members for publication both in the Journal and in other similar medical periodicals. The Board wishes to express its appreciation to all contributors and to those who have assisted with the various departments. Any criticism or suggestions which the House of Delegates, the Council, officers or members of the Society may care to make will be gladly received by the Board.

The reports of the Councilors from over the State were read and approved. Areas which are sparsely populated have trouble in having county meetings. We would encourage the formation of group meetings in these districts, so that scientific meetings could be held. We would also suggest that members of sparsely settled communities be allowed to join with near-by county societies as associate members where it seems advisable or convenient.

The report of the Defense Board shows that it has operated satisfactorily again during the year 1941-42.

The following comments are made in regard to the report of the Executive Secretary: The foremost activity of the Society during the past year has been pertaining to the war effort. The Officers, Councilors, and Committee on Medical Preparedness together with the Procurement and Assignment Service have been active and as the result over 200 Kansas doctors are now serving in the military forces. Kansas ranks very favorably with any other state in this matter. Physicians left at home will have added responsibilities in caring for the sick, making medical examinations of the draftees and caring for the industrial situations that have arisen in numerous communities.

The care of the indigent has also received considerable attention and plans are being worked out so that physicians of the State can be assisted in this class of work. The Kansas State Board of Health and its Secretary, Dr. F. C. Beelman, are most cooperative in their work with The Kansas Medical Society. The Society has attempted to assist the Kansas State Hospital Association in the institution of its group hospitalization program. A corporate charter has been obtained by the Kansas State Hospital Association for the organization, a full time Secretary has been employed, an office is now being established in Topeka, and the Hospital Association plans to offer the sale of hospital insurance policies of this type within the near future. Numerous other activities of importance have been under consideration and will appear under various committee reports. Several resignations have occurred during the year and are listed in the detailed reports. The Executive Secretary pays tribute to the excellent administration of Dr. Blake, our President. His year has been filled with many unusual difficult problems and has required much of his time and effort. The Kansas Medical Society is deeply obligated to Dr. Blake.

Respectfully submitted,

Reference Committee on Reports
of Officers and Councilors.

J. J. Brownlee, M.D., Chairman
E. F. Clark, M.D.

Dr. Fegly announced that the voting strength at this session of the House of Delegates was sixty-seven votes.

The report of the Reference Committee on Officers and Councilors Reports was adopted by section and upon a motion by Dr. N. C. Nash of Wichita, second and carried, was adopted as a whole.

Dr. Morgan, the Chairman of the Reference Committee on Committees and Resolutions then submitted the following report, which had been prepared by that committee.

COMMITTEE ON AUTOMOBILE ACCIDENTS AND FRACTURES

The Committee held one meeting during the year. Dr. Blake, Dr. Grove and Mr. Munns were present.

Accomplishments included interviews with interested organizations and the presentation of an exhibit at the State meeting.

Other objectives of the Committee were discussed.

ADVISORY COMMITTEE TO THE KANSAS MEDICAL AUXILIARY

Particular progress is evidenced by the work done on lay educational matters, the distribution of Hygeia magazine, the study of nutrition, the securing of American Medical Association health speakers, and aid to the National Defense Program through the Red Cross, first aid, nursing and dietetics.

A press and publicity program was inaugurated.

The chairman urges appreciation, sympathy and encouragement by the profession of the work done by the women.

COMMITTEE ON CHILD WELFARE

One meeting was held on October 26, 1941, with the following report:

1. That respirator facilities in the State seem adequate in all areas with the possible exception of two districts.

2. A proposed Legislative enactment for the required immunization and vaccination against diphtheria and small pox has been suggested.

3. The Children's Bureau of the United States Department of Labor has recently requested that agencies receiving federal financial assistance for crippled children should utilize the services of a medical consultant, and Dr. Paul Carson has agreed to assist the Kansas Crippled Children's Commission in this manner next year.

COMMITTEE ON CONSTITUTION AND BY-LAWS

One meeting of this Committee was held during the year. The printing of the Constitution and By-Laws and Code of Ethics has been unavoidably delayed, but will be in the mail soon.

New amendments under consideration include:

1. Official inclusion in the By-Laws of provisions for the use of Reference Committees, at the House of Delegates meeting.

2. The formation of a Nominating Committee.

3. Limiting service of members on committees to three consecutive years.

4. Limiting American Medical Association Delegates to three consecutive terms.

5. Limiting defense assistance.

6. Permitting membership in a county of non-residence with consent of resident county.

During the coming year it was decided to print in the Journal some of the proposed amendments to the By-Laws to be voted on at the 1943 session.

COMMITTEE ON CONSERVATION OF EYESIGHT

The Committee has worked in close harmony with the Kansas State Board of Social Welfare and the office of the State Consulting Ophthalmologist in regard to the prevention and correction of blindness.

The Committee did not think it advisable to conduct post-graduate courses in this specialty.

The Committee desires that our Delegates to the American Medical Association be instructed to vote against repeal of the amendment which is now in force and which forbids oculists to engage in certain types of work.

COMMITTEE ON CONTROL OF CANCER

The Committee reports the work done on public education on cancer of the stomach through the publication of 50,000 copies of a pamphlet from the Kansas State Board of Health printed for lay distribution.

Large amounts of literature have also been sent out through cooperation of the Women's Field Army.

Several exhibits on this subject have been presented at the scientific exhibit section of the meeting this year.

COMMITTEE ON CONTROL OF TUBERCULOSIS

This Committee did not have a meeting during the year.

Dr. F. C. Beelman was made the Secretary of the Kansas State Board of Health. Dr. H. L. Hiebert is the new Director of the Division of Tuberculosis Control.

The Committee has been working with the State Board of Health in rehabilitating rejected selective service men.

COMMITTEE ON ENDOWMENT

An attempt was made to plan a way to finance a medical science building at the University of Kansas in Lawrence.

The Committee invited any one knowing of available funds, to contact some member of the Committee or the University of Kansas Endowment Association.

COMMITTEE ON HISTORY

The Committee has worked with the various government groups in close cooperation in furnishing physicians for military service. At the present writing there are approximately 200 physicians in service from Kansas.

Post-graduate courses were given throughout the year by various committees. Much work has been done on the subject of medical care of the indigent and a number of additional counties have adopted the plans. Recommendations have been made as to the care of farm families. Note has been made of the new Director and new Secretary of the Kansas State Board of Health and various changes in the personnel.

Several members of the Society have been elected to national medical offices throughout the year.

The membership of the Society for 1941-42 compares very favorably with recent years.

COMMITTEE ON HOSPITAL SURVEY

The Committee reports the passing of an enabling act wherein a corporation could be organized for the sale of hospital insurance to the general public. The program will be announced in detail within the near future.

A report on the number of new hospitals and new additions and improvements was also made.

COMMITTEE ON INDUSTRIAL MEDICINE

The Committee has accomplished the five purposes of its program for the year:

1. Revision and completion of the Kansas Workmen's Compensation fee schedule.
2. Publication of an article by the Commissioner of Kansas Workmen's Compensation Commission.
3. Presentation of a post-graduate course on evaluation of disabilities.
4. An exhibit prepared for the State meeting.
5. Publication of a brochure showing the new Workmen's Compensation fee schedule, and abstract of the compensation law, etc.

COMMITTEE ON MEDICAL SCHOOLS

The Committee met once during the year and various problems of the University of Kansas School of Medicine were discussed. It is hoped that the pre-clinic division of the medical school at Lawrence can be brought together in one building.

The Library Department of the University of Kansas School of Medicine has a package service available to the members of the profession and it greatly desires to have doctors use this service.

The medical school has offered post-graduate courses in several subjects, and will continue doing so.

At the present time the building and grounds of the medical school represent an investment of \$2,500,000 and plans are for still further enlargement.

COMMITTEE ON PHARMACY

The Committee reports no special action because of defense and war activities.

COMMITTEE ON PUBLIC POLICY

This Committee held a joint meeting with the Council on February 22, wherein several important matters were considered.

Since 1942 is not a regular Legislative year, the Committee work during the year has consisted mainly of plans and preparations for the future.

COMMITTEE ON CONTROL OF HEART DISEASE

The Committee sponsored its third annual post-graduate course in cardiovascular diseases. Dr. Tinsley R. Harrison conducted the study this past fall. The 1942 course is to be given by Dr. Sam Levine. At the time of this report there have been thirty-two matriculants who applied for the next course.

COMMITTEE ON VENEREAL DISEASE

Because of the enormous increase in activity at the two Army posts in this State and at Kansas plants for production of war materials and supplies, a large number of workers are moving into localities where the housing accommodations are inadequate and living conditions are otherwise unfavorable. An increase of venereal disease has been in evidence. The Committee recommends that the Society should go on record as approving an agreement with the United States Army, Navy, and Public Health Service as to the best methods of control of disease in the United States forces and war industries. The Society has been given the opportunity of cooperating with Army officials in checking the conditions around points of military concentration. The rehabilitation program for selectees rejected because of positive serology has caused the proposal of a plan by which these men will be supplied with sound advice and be referred to their own physicians for treatment provided in those cases where they are unable to pay.

One new clinic has been established during the year at Manhattan. It is probable that a number of others will be established during the coming year.

COMMITTEE ON NECROLOGY

The report of this Committee gives the age, the date, and the cause of death of twenty-four members of the Society from April 1, 1941, to April 1, 1942. And we quote from the report "May I suggest a few minutes of silence at this time in honor of our departed members."

COMMITTEE ON SCIENTIFIC WORK

The Committee on Scientific Work was unable to submit a report since Dr. John M. Porter, Chairman, is now serving in the United States Navy.

COMMITTEE ON MEDICAL ECONOMICS

The Committee on Medical Economics recommends the following:

1. That the State Society, the county societies and the membership cooperate with the Kansas State Board of Social Welfare in developing plans for medical care of the indigent.

2. That the State Society cooperate with the Kansas State Hospital Association in the institution and operation of its group hospitalization program.

3. That medical service plans whether offered by government or private agency should be carefully studied in regard to free choice of physicians, and as to whether the medical care offered therein is unhampered and whether the fees charged are adequate for essential medical care.

4. That full cooperation should be given in the handling of medical service for laborers and farm families.

5. That the present Farm Security Aid program be discontinued due to certain changes in needs, plans and policies.

6. That owing to the diversity of problems in counties, the medical personnel of each county should arrange to handle its own medical economic problems.

7. That recommendations be forwarded to the Kansas High School Athletic Association suggesting free choice of doctors of medicine under its medical program and that fees for medical service performed under the program should be based upon the fee schedule authorized by the Kansas State Commission of Workmen's Compensation for treatment of industrial injuries.

8. That the Committee recommends to all members that mileage charges in connection with the provision of medical service to farm families should be eliminated; and that a method be substituted, therefore, wherein fees for farm medical services shall be based on the nature and extent of individual services rendered.

COMMITTEE ON LOCATIONS

The Committee on Locations held no meeting during the past year, due to the war situation. However, the Committee through the central office, were able to place a considerable number of physicians in communities where they were most needed.

COMMITTEE ON MATERNAL WELFARE

There were two meetings during the year. The time and energy of the Committee was devoted to the following activities:

First: post-graduate programs. Second: mothers training classes. Third: suggestions for conduct of obstetrical cases in hospitals.

Six post-graduate meetings were held in various parts of the State throughout the year. The Committee has under consideration the problems of organizing mother's training classes in obstetrical care for Kansas mothers, and the matter of obtaining the cooperation of Kansas hospitals in enforcing rules for conduct of obstetrical cases.

COMMITTEE ON LEGAL MEDICINE

The Committee on Legal Medicine, a joint committee of attorneys and physicians, completed its first year's service. Two meetings were held during the year and the following program was formulated at the first meeting, adopted and activated at the second meeting: that the primary function of the Committee shall be to act as a liaison agency between the medical profession and the legal profession, which the Committee believes is an important and needed function; that the Committee shall assist in disciplining physicians who give inaccurate and unscientific testimony while serving as expert medical witnesses; that the Committee shall assist in furthering the use of medical commissions, expert testimony, and other methods for the provision of more accurate and reliable assistance in cases involving medical jurisprudence; that arrangements shall be made for providing a greater number of county and area meetings wherein legal speakers may speak to physicians on legal problems and physician speakers may speak to attorneys on medical problems; that it shall also arrange for a wider use of interchange of articles in the journals of the two professions; and that it shall study ways and means wherein the present Kansas Coroner Law can be improved and made more effective.

Respectfully submitted,

Reference Committee on Reports
of Committees on Resolutions
Philip W. Morgan, M.D., Em-
poria, Chairman

C. E. Joss, M.D., Topeka
C. K. Schaffer, M.D., Topeka
C. W. Erickson, M.D., Pittsburg

Upon motions by Dr. Morgan, seconded and carried, the report of the Reference Committee on Committees and Resolutions was adopted by section and as a whole.

Dr. Blake complimented the Reference Committees on their excellent reports and for the splendid assistance they rendered the House of Delegates thereby.

Dr. Blake asked if there were any reports which had been overlooked or whether there were any resolutions which members of the House desired to introduce. None was reported.

Dr. Blake announced that Mr. Claude I. Depew, who is Co-Chairman of the Kansas State Bar Association-Kansas Medical Society joint Committee on Legal Medicine was present at the meeting and invited Mr. Depew to make any comments he desired to make on that subject or other subjects. Mr. Depew discussed the work the joint Committee has performed to date and the possibilities therein which he believes can be accomplished in the future.

Dr. Blake then introduced Mr. Kirke Dale, of Arkansas City, the attorney for the Society; Mr. Theo. F. Varner of Independence, the attorney for the Kansas State Board of Medical Registration and Examination; Dr. J. B. Carter of Wilson, the only physician member of the Kansas Legislature, and Dr. J. F. Hassig of Kansas City, the Secretary of the

Kansas State Board of Medical Registration and Examination, who made brief talks.

Dr. Blake invited Dr. F. L. Loveland of Topeka, Chairman of the Kansas Committee on Procurement and Assignment of Physicians to make any comments in regard to that program which he desired to make. Dr. Loveland stated that he did not believe he needed to do so inasmuch as the subject would be fully discussed at meetings to be held on May 13.

Dr. Blake announced that Lt. Col. Seth A. Hammel, Medical Director of the Kansas Selective Service was in attendance at the meeting and would discuss the medical phases of the Selective Service program and also the contemplated program for provision of re-habilitation medical and dental treatment to rejected Selective Service registrants. Col. Hammel presented a discussion of these topics.

Discussion followed concerning whether an annual session should be held next year and if so as to the type of meeting. Upon a motion made by Dr. L. F. Barney of Kansas City, seconded and carried, it was agreed that this matter should be referred to the Council for decision.

A question was asked by Dr. A. W. Fegtly of Wichita, as to whether any action had been taken as yet regarding waiver or refund of dues for members serving in the military forces. Dr. Blake stated that the Council has previously acted upon this and that he believed full procedure now existed for the handling of this matter.

Dr. Blake then made the following announcements:

That the next session of the House of Delegates will be held in this same room at 8:30 a.m. on Thursday, May, 14.

That Councilors for the First, Second, Seventh, and Eighth Districts, will be elected at the Thursday meeting; that Councilors are elected by a caucus of the Delegates from each District; that the Councilor for the Seventh and Eighth Districts, Dr. F. R. Croson and Dr. L. S. Nelson, are not eligible for reelection by reason they have served two consecutive terms; and that it is requested the Delegates from the First, Second, Seventh and Eighth Districts hold their caucuses in advance of the Thursday meeting and be ready to announce their selection at that time.

Dr. Leo J. Schaefer of Salina, stated that the Saline County Medical Society desires to recommend Dr. H. N. Moses, Dr. J. W. Neptune, Dr. O. D. Walker, Dr. E. G. Ganoung, Dr. E. R. Cheney, and Dr. M. J. Brown for Honorary Fellowship in the American Medical Association, that it understands approval by the Society House of Delegates is necessary for this procedure and that it would appreciate a ruling as

to proper action it shall take in this regard. Upon a motion made by Dr. J. F. Hassig, of Kansas City, seconded and carried, it was agreed that this matter should be acted upon at the Thursday meeting of the House of Delegates.

Adjournment followed.

SECOND SESSION OF THE HOUSE OF DELEGATES

The second regular session of the House of Delegates was held at the Hotel Allis in Wichita on Thursday, May 14, 1942. The meeting was called to order by Dr. C. D. Blake, President, at 9 a.m.

Dr. Blake asked whether there were any further reports from the Reference Committee on Reports of Officers and Councilors or from the Reference Committee on Reports of Committees and Resolutions. None was reported.

Dr. Blake then called for further discussion of any unfinished business. Hereunder was discussed the matter in regard to Honorary Fellowships in the American Medical Association presented by the Saline County Medical Society at the Tuesday session of the House. On a motion made by Dr. Fegtly, seconded and carried, it was agreed that the Councilor for the Eighth District should investigate the recommendations made and that upon his endorsement of the recommendations, the Saline County Medical Society was thereby authorized to present the names to the American Medical Association with approval by the Society House of Delegates.

Dr. Blake then asked for the presentation of any new business. None was reported.

The next item was the annual election of Officers and Councilors.

Dr. John L. Lattimore of Topeka was elected President-Elect for 1942-43, and as President for 1943-44; Dr. Marion Trueheart of Sterling, was elected First Vice-President for 1942-43; Dr. W. P. Callahan of Wichita was elected Second Vice-President for 1942-43; Dr. F. R. Croson of Clay Center was elected Secretary for 1942-43; Dr. Geo. M. Gray of Kansas City was re-elected Treasurer for 1942-43.

Dr. J. W. Randell of Marysville was re-elected as Councilor for the First District for a term of three years; Dr. O. W. Davidson of Kansas City was re-elected as Councilor of the Second District for a term of three years; Dr. R. R. Cave of Manhattan was elected as Councilor of the Seventh District for a term of three years; and Dr. Ben H. Mayer of Ellsworth was elected as Councilor of the Eighth District for a term of three years.

Dr. J. F. Hassig of Kansas City was elected as Delegate-Elect to the American Medical Association

for the 1943 and 1944 meetings of that organization.

Upon a motion made by Dr. L. F. Barney of Kansas City, seconded and carried, the expenses of the two Delegates, the incoming President, and the Executive Secretary, were authorized to be paid by the Society for attendance at the 1942 meeting of the American Medical Association.

Dr. H. H. Atkins suggested that by reason of the probable financial problems to be experienced by reason of the war, the Society should establish and carefully conduct its affairs under a budget. Upon a motion made by Dr. S. D. E. Woods of Osawatimie, seconded and carried, the President, Secretary, and Treasurer were authorized to establish a budget for this purpose.

Discussion followed concerning the excellent assistance Dr. F. L. Loveland of Topeka has given in conjunction with the Procurement and Assignment program. Upon a motion made by Dr. Hugh Hope of Hunter, seconded and carried, it was agreed that Dr. Loveland should be compensated by the Society for any travel expenses incurred in that connection.

Upon a motion by Dr. Trueheart, seconded and carried the appreciation of the Society was extended to the Sedgwick County Medical Society and the other host county societies for the excellent program and arrangements provided for the 1942 annual session.

Upon a motion made by Dr. Loveland, seconded and carried, the Executive Secretary was instructed to send a telegram and a floral gift to Miss Joyce Ryerson as a token of the esteem with which she is held by the Society.

Upon a motion made by Dr. Trueheart, seconded and carried an expression of appreciation of the Society was extended to Dr. Blake for his excellent service and assistance as President.

Dr. Loveland then made a motion, which was seconded and carried, to extend a vote of appreciation to Dr. W. M. Mills of Topeka and the members of the Editorial Board, for their splendid management of the Journal.

Dr. Blake then installed Dr. Henry Tihen of Wichita as President of the Society for 1942-43.

Adjournment followed.

The following are the reports of Councilors, Officers and Committee Chairmen not published in the April issue of the Journal:

The following is the report of the Councilor of the Fourth District:

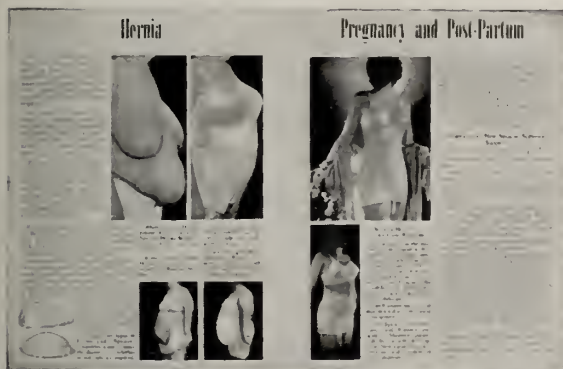
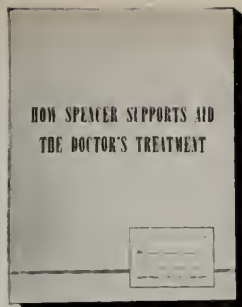
TO: THE HOUSE OF DELEGATES:

By correspondence and individual contact an attempt has been made to gain information concerning what

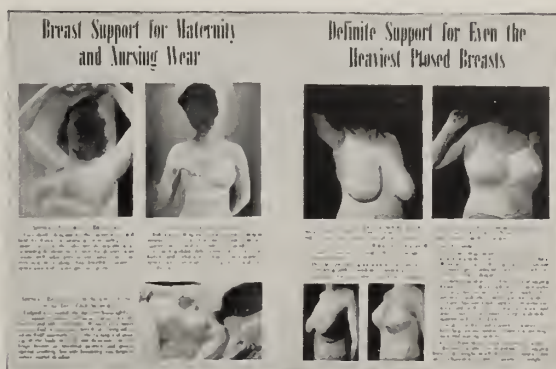
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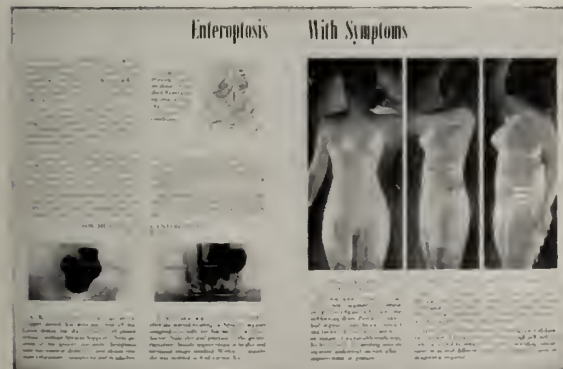
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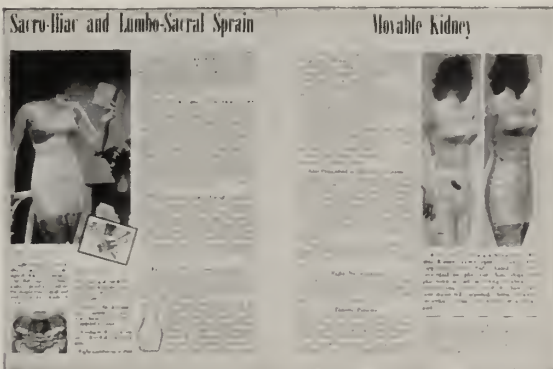
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the attitude of the men is on certain questions and to learn what each local county society activities consist of.

Coffey county holds only one meeting a year; Morris and Chase counties two or three meetings a year; Shawnee, Osage and Lyon counties ten meetings a year. In Lyon county the meetings are planned a year ahead of time but in all the other counties in the District the program is made up only a month in advance. In Morris, Chase, and Coffey counties there is no regular meeting date. In three of the above counties namely: Morris, Chase, and Coffey no scientific meetings are held and the men in the county go elsewhere for scientific meetings each month. In neither of the two larger counties is there any effort to have papers submitted for publication in the State Journal. The county dues range from none to \$10.00 a year in the counties in this District. The Farm Security Association is functioning in two of the counties and according to the secretary is satisfactory. In answer to the question to whether a physician is needed to be placed in any of the towns in the counties it was noted that White City should have a physician and Waverly and Gridley also need physicians. In the five reporting counties there were seven physicians in all who do not belong of the local or State Medical Society.

Since it was shown that in several counties in this District the societies do not have scientific meetings and the impression was given that the men attend those meeting in other larger county societies, on the suggestion from men from the small county societies a questionnaire was gotten out to all the men in Wabaunsee, Coffey, Morris, Osage and Chase counties. It was impossible to reach any definite conclusions from the answers given to the questions however I think it is of sufficient importance though not definitely conclusive to mention the answers. It was the impression that the men feel that a county society was of an advantage in each of these counties. Many of the men would also like an active affiliation with a neighboring county society. A majority favored amending the By-Laws of The Kansas Medical Society to permit a physician to belong as an active member to a neighboring society in addition to his own society.

I would like to recommend that such an amendment be drawn up. I believe that the Councilors over the State might well make use of the questionnaire form of data accumulation in preparing their annual report.

Respectfully submitted,
Philip W. Morgan, M.D.,
Councilor Fourth District

The following is the report of the Councilor of the Fifth District:

TO: THE HOUSE OF DELEGATES:

Your Councilor for the Fifth District begs to report that the medical condition in McPherson, Stafford, Marion, Barton, Harvey, Reno and Rice counties continues in a healthy condition. The societies are functioning, fully alert to the war needs, and I believe will contribute their full quota of medical men to the Army and Navy service. The joint meetings which have been held in McPherson, Marion and Harvey counties have proved to be especially valuable and have been well attended.

Your Councilor looks forward to more active per-

sonal contact with the members of the societies this year than was possible during the year just past on account of his being in the East for several months during the past year.

Respectfully submitted,
John L. Grove, M.D.,
Councilor, Fifth District.

The following is the report of the Councilor of the Sixth District:

TO: THE HOUSE OF DELEGATES:

During the past year the societies of the Sixth District have all been very active and have had some exceptionally good meetings. Each society has cooperated in every request and I wish to take this opportunity to thank the officers of each individual society.

Respectfully submitted,
W. P. Callahan, M.D.,
Councilor, Sixth District.

The following is the report of the Councilor of the Tenth District:

TO: THE HOUSE OF DELEGATES:

The support of all the members in this district to the problems that have arisen was inspiring to see. At no time was cooperation lacking.

I am truly pleased and thankful for all assistance given.

Meetings of the local societies were unusually well attended.

I believe that the physicians are awake and understand the tasks that are before us.

May the next year of our increased problems receive the same consideration.

Respectfully submitted,
Otto A. Hennerich, M.D.
Councilor, Tenth District

Clarence G. Munns, Executive Secretary, submitted the following report:

TO THE HOUSE OF DELEGATES:

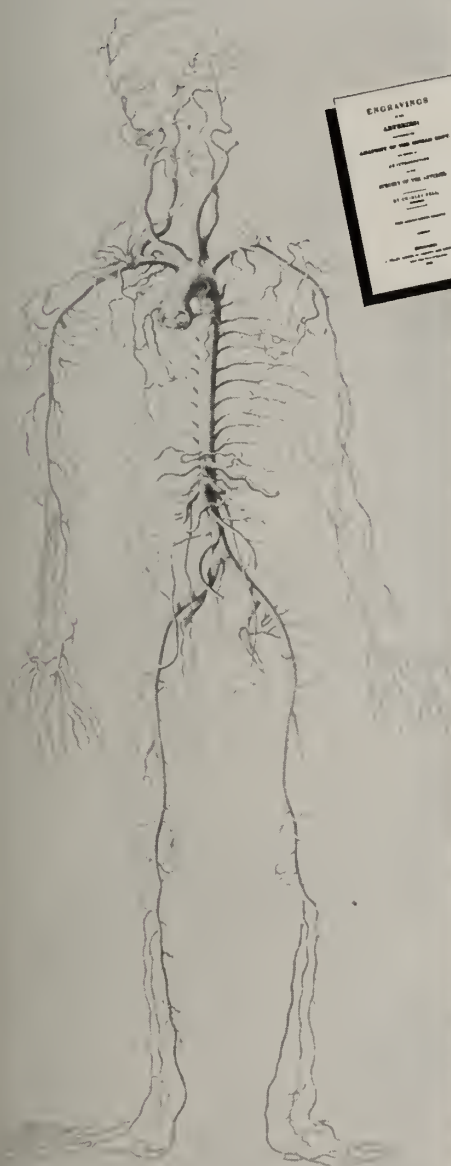
We have attempted to list below a report on behalf of the central office for the past year.

The foremost activities of the Society during that period, have, of course, pertained to the war effort. The Officers, Councilors, and the Medical Preparedness Committee of the organization and the Kansas Committee on Procurement and Assignment Service for Physicians have held numerous meetings and have been very active in preparing plans and procedures wherein the Kansas profession may contribute its part in winning the war. Likewise, the county medical societies have assisted materially in the provision of arrangements for civilian defense, civilian and military necessities. There are approximately 200 Kansas doctors of medicine now serving in the military forces. This ratio on the basis of developments to date and on the number of available physicians compares favorably with that of any other state. The Kansas Procurement and Assignment Service program has also been praised in Washington and in other places, as one of the best planned and most efficient in the country. It is obvious that Kansas and all other states will need to give many hundreds of additional physicians to the military

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forces and it is also obvious that those physicians who find it necessary to remain at home will be confronted with many problems wherein the provision of medical service to the public is the only major consideration. We believe, though, that the Officers and Councilors of the Society, its Committee on Medical Preparedness and the Kansas Committee on Procurement and Assignment Service have established a program wherein these objectives can be met to the fullest extent necessary.

Also, in conjunction with the war effort, the Society has continued its efforts to assist Kansas Selective Service in all ways possible. A change occurred during the year in the method of providing physical examinations for selective service registrants, and the new program was installed in all Kansas counties without difficulty. Kansas Selective Service has recently announced that a program for physical re-habilitation of rejected registrants will be commenced within the near future. Registrants who have certain types of disabilities, and who are approved by Selective Service, will be authorized to have their disabilities corrected at governmental expense. The medical and surgical work therein will be provided in this State by doctors of medicine and the Kansas Selective Service has ruled that all Kansas doctors of medicine may apply to be approved for the provision of those services. Brigadier General M. R. McLean, the Adjutant General of the State, Lieutenant-Colonel R. F. Montgomery and Lieutenant Colonel Seth A. Hammel, the director and medical director respectively of Kansas Selective Service and numerous Washington officials have on many occasions praised the assistance the Kansas profession has furnished in conjunction with Selective Service, and they have stated that to the physicians who have participated therein should go much of the credit for the efficiency which has been demonstrated in Kansas selective service activities.

Considerable progress has been made on the subject of indigent medical care during the past year. The Kansas State Board of Social Welfare has cooperated to the fullest extent in this regard, and was successful in obtaining federal government approval of a method wherein financial participation from that source may be utilized to assist counties in providing for the expense of indigent medical care.

The members of the Kansas State Board of Health, its new Secretary, Dr. F. C. Beelman, and the employees of that board have cooperated with the Society in all matters to the fullest extent. Kansas may undoubtedly take pride in the efficiency of its Board of Health and its programs.

The Society has attempted to assist the Kansas State Hospital Association in the institution of its group hospitalization program. A corporate charter has been obtained by the Kansas State Hospital Association for the organization, a full time secretary has been employed, an office is now being established in Topeka, and the hospital association plans to offer the sale of hospital insurance policies of this type within the near future.

Most of the other activities of the Society including projects attempted and completed, post-graduate activities, liaison relationships with other groups and organizations, and other matters have been commented upon in the other reports furnished by the various officials and committees. Hence, no attempt has been made to reiterate them herein.

Several resignations of official positions occurred during the year. Dr. John Porter of Concordia resigned his position as Secretary of the Society and as Chairman of the Committee on Scientific Work by reason of his entry into the service of the Navy; Dr. Omer M. Raines of Topeka resigned as Chairman of the Committee on Control of Tuberculosis by reason of his entry into the Army; and Dr. B. I. Krehbiel of Topeka, who also entered the Navy, resigned his position as chairman of the Committee on Child Welfare.

The report of income and expenditures of the Society is as follows:

INCOME

1942 Dues	\$18,750.00
Payment of dues in arrears	3,021.25

Total Income\$21,771.25

EXPENSE

GENERAL FUND

Salaries	\$ 8,580.14
Office Rental	540.00
Telephone & Telegraph....	784.60
Postage & Express	397.45
Stationery & Supplies.....	929.37
Travel	1,451.18
Committee Expense	2,147.64
Appropriation to Kansas	
Medical Auxiliary	200.00
Social Security & Other	
Taxes	392.66
Miscellaneous	241.80
	<hr/>
	\$15,664.84

DEFENSE FUND

Expense	\$ 1,716.94
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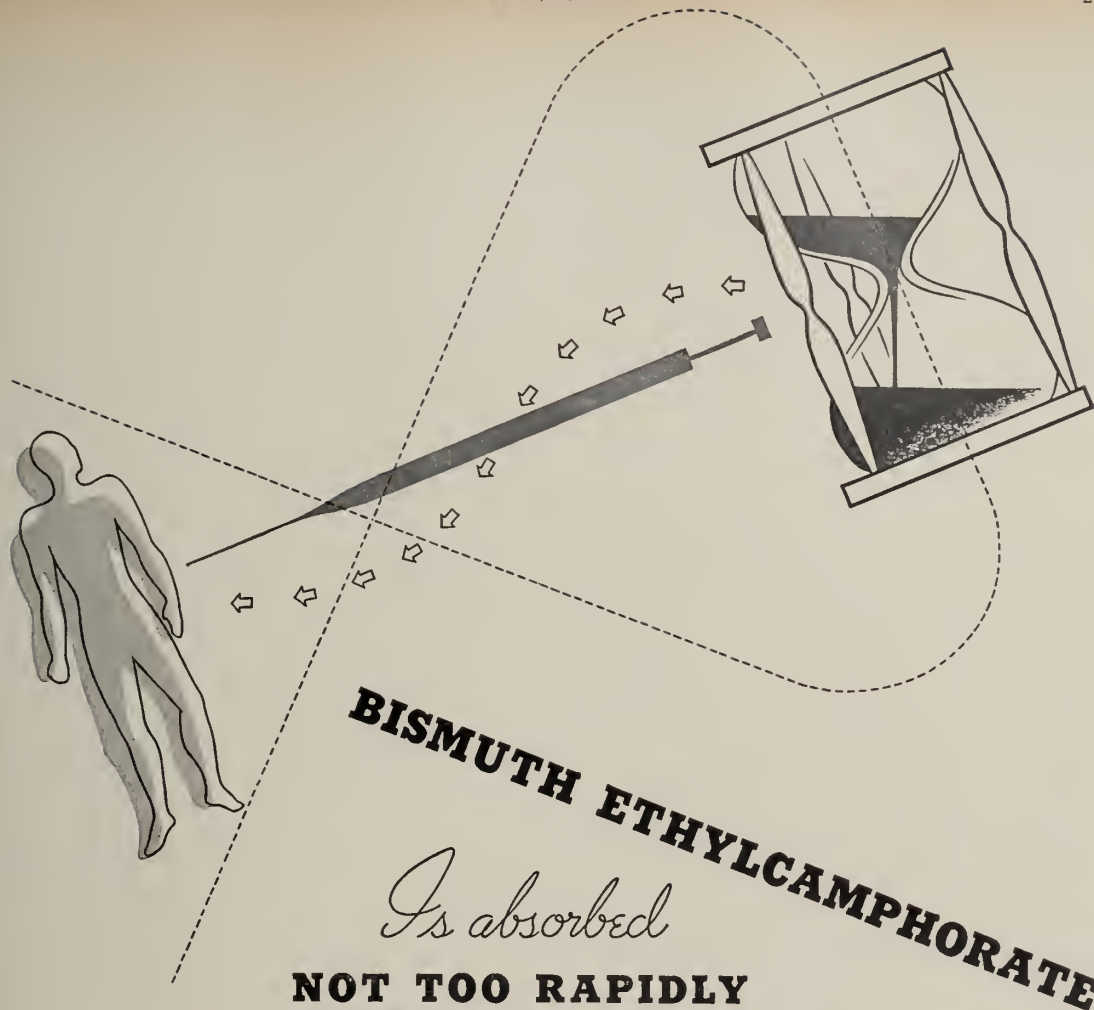
\$17,381.78

INCOME AND EXPENSE

Income	\$21,771.25
Expense	17,381.78
	<hr/>
Surplus	\$ 4,389.47

The Journal has continued to operate in good financial condition. It pays its own expenses including the salary of one full time assistant in the central office, and no financial assistance is provided by the Society. Much credit is due Dr. W. M. Mills, Dr. L. E. Eckles, Dr. L. R. Pyle, Dr. R. B. Stewart, and Dr. Don C. Wakeman for their excellent management and supervision of the publication. They spend a considerable portion of their time in that regard, and the fact that they do so without any form of compensation should entitle them to the appreciation of the entire membership.

The central office personnel has consisted during the past year of Miss Joyce Ryerson, Miss Jane Griggs, Miss Miriam DuMars, Mrs. Margaret Foster, and Mrs. Mateel Todd and the writer. As most members know, Miss Ryerson was forced to resign her position in November, 1941 by reason of illness. Miss Jane Griggs was married in March, 1942 and thus resigned her position. Miss DuMars is now handling the work formerly handled by Miss Ryerson and Miss Griggs. Mrs. Foster has been employed on a part time basis to assist in other clerical work of the office. Mrs. Todd is employed in the work in conjunction with the Journal.



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In conclusion we would like to pay tribute to the excellent administration of Dr. Blake. His year was filled with many difficult problems and decisions, and those who worked with him know that he placed the Society foremost among his activities. His counsel and advice, his wide acquaintance, and his excellent ability were responsible for many of the accomplishments during his term. We greatly enjoyed working with him and we feel every member agrees that he has been a particularly efficient and capable President. Tribute should also be paid to the other Officers. Councilors, the committees and the other members who have attended many meetings, given freely of their time and money, and in many other ways contributed to the welfare and progress of the Society.

I would again like to extend to the House of Delegates my appreciation for the privilege of having been your employee. You have extended me many courtesies and kindnesses which I shall never forget. The ideals which you have and the justness and excellence of the matters you desire to accomplish make it possible for you to have as excellent and efficient organization as could be desired. We in the central office only wish our capabilities were such that this could be more easily and completely accomplished.

The following is the report submitted by Earl Mills, M.D., Chairman of the Committee on Legal Medicine:

TO THE HOUSE OF DELEGATES:

The Committee on Improvement of Medico-Legal Relationship, which has operated during the past year as part of a joint Committee of doctors and lawyers, the doctors being appointed by the President of The Kansas Medical Society, makes the following report and recommendation:

RECOMMENDATIONS.

1. We recommend that this Committee be continued next year, as a joint Committee of doctors and lawyers, appointed by the Presidents of the Bar Association and the Medical Society.

2. We recommend that the Bar Association endorse a plan of disciplinary action by the Medical Society to consider and handle instances where the judge of a court believes that medical expert witnesses have given evidence that was not honest and sincere; that the details be left to the Medical Society, but that the plan be along the lines of the "Minnesota Plan", in use in the State of Minnesota, and under which the Medical Society would establish a standing committee of doctors to review the record of any expert medical testimony where the judge had reason to believe that a doctor witness had not given honest and sincere testimony.

3. We recommend that a study be made of the possibility of the courts making greater use of doctors and other expert witnesses as examiners or commissioners appointed by the court to make impartial reports or give impartial testimony on issues involving the consideration of expert opinions; also the enactment of new legislation along that line if necessary, the right of trial by jury and the right of cross-examination to be properly preserved.

4. We recommend that one of the activities of the joint committee should be the sponsorship of joint meetings to be held in various localities of the state,

to be attended by doctors and lawyers, where they would engage in social activities and informal discussions of matters of mutual interest, and also conduct programs of papers or speeches on subjects in which both groups are interested.

5. We recommend that provision be made for doctors to appear on conventions and institute programs of local and State Bar Associations, and for lawyers to appear on conventions and institute programs of the State and local medical society; the lawyers so appearing to discuss legal matters that might be of interest and benefit to the doctors and the doctors so appearing to discuss medical matters of interest and benefit to the lawyers. And in that connection the Bar Association, either through its Institute Committee, or through this Committee, should furnish a list of lawyers residing in various parts of the State who might be available to doctors for appearance on their program, and likewise, the Medical Society should furnish the Bar Association with a list of doctors for similar appearances on programs of lawyers' meetings.

6. We recommend that arrangements be made for articles written by lawyers to be printed in the Journal of The Kansas Medical Society on such subjects as legal obligations of doctors, their rights and obligation in connection with the giving of medical testimony, questions arising in malpractice cases, the right and duty to claim the privilege of confidential communication, etc.; and likewise for articles written by doctors on medico-legal subjects, to be published in the Journal of the Bar Association.

7. We recommend that joint clinics or institutes be held at which subjects of mutual interest to doctors and lawyers would be presented by selected speakers or writers and discussed by doctors and lawyers attending the clinics or institutes.

8. We recommend that the Bar Association join the Medical Society in sponsoring a movement to get the Legislative Council to make a study of the Coroner Laws of Kansas, with a view to modernizing and improving the coroner setup in this State.

REPORT

This Committee is a new one. It is not only the first one of its kind in Kansas, but is probably one of the first instances in the United States where a joint Committee of doctors and lawyers has been appointed to promote good will between the two professions, and attempt to work out a constructive program of activities that will be of benefit to the doctors and lawyers and also to the general public by a coordination of beneficial activities and interests. The President of The State Medical Society appointed a Committee of the following doctors:

Dr. Earl L. Mills, Wichita, Kansas
Dr. L. S. Nelson, Salina, Kansas
Dr. J. L. Lattimore, Topeka, Kansas
Dr. E. J. Bribach, Atchison, Kansas
Dr. J. J. Brownlee, Hutchinson, Kansas
Dr. C. D. Blake, Hays, Kansas

to work as a part of the joint Committee of which this Committee was a part, representing the Bar Association.

Two meetings have been held during the year. At the first meeting the matter of outlining program of activities was the principal topic of discussion. Many matters were considered and placed before the members of the joint Committee for study until another meeting could be held.

The Library of the Medical Department of the University of Kansas has every desire to be of service to the medical profession in the state. Any physician who wishes to avail himself of the facilities of the Library will be welcome both in the use of its periodicals, bound volumes of periodicals, and monographs and text-books.

Under certain circumstances, provided the volumes are not being actively used by the students, the Library will send such volumes as are needed to physicians in the state, on request, for a period of one week, provided carriage charges are paid both ways.

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The second meeting was held at Topeka on April 12, 1942. The matters which had been discussed at the previous meeting were again brought before the Committee for the purpose of determining whether or not definite recommendations should be made to the respective State conventions concerning them. Additional matters were also brought up for discussion. The result was a unanimous decision by all those present to make the recommendations which are set out at the beginning of this report.

President Sheridan of the Bar Association attended one of the meetings of the Committee and Dr. Blake, President of The Kansas Medical Society and also Clarence G. Munns, Executive Secretary of the Medical Society attended the other meeting. The Medical Society has invited the lawyer members of this Committee to attend the annual convention at Wichita, and the Bar Association has invited the doctor members of the Joint Committee to attend any session of the meeting of the Bar Association.

While the purpose of the Committee during the past year has been primarily getting acquainted and to formulate plans for getting started along certain lines of activities, there is a strong feeling among not only the members of the joint Committee but also the Executive Officers of both State associations, that a Committee such as this can do a world of good, and that the benefits will not only be worth while to the individual members of the professions but also to their respective organizations and to the public at large.

NEWS NOTES

ARMY RECRUITING BOARD

Throughout the medical preparedness program during the past several years the United States Government has demonstrated every desire and willingness to eliminate red-tape and inefficiency in the handling of the medical defense program and the procurement and assignment of physicians for the military forces. Certainly no more efficient program could be devised than the present procurement and assignment plan wherein civilian committees are authorized to grant approval as to availability or unavailability and wherein all other efforts have been provided to blend civilian necessity with military necessity to the fullest extent possible.

Another step for further progress in that direction has been taken during the past month. Each state has been supplied with an Army Recruiting Board composed of a medical officer, a procurement officer and the necessary enlisted personnel. These boards have been empowered with authority to interview doctors of medicine and doctors of dental surgery to advise them concerning commissions and assignment, and to assist them in obtaining commissions without delay. As a matter of fact the boards have been authorized to interview physicians, to arrange for their physical examination, and to commission and administer the oaths of office as soon as physical examination reports have been returned. The board too can request temporary deferment from active duty in order to permit physicians to have adequate time to adjust their affairs.

Physicians under thirty-seven years of age are being granted commissions of First Lieutenant and those over that

age to forty-four inclusive are granted the rank of Captain. Applications from physicians forty-five to fifty-four years of age and from those under that age wherein exceptions can be made in the rank above stated are forwarded by the board to Washington for consideration.

The Kansas Board opened its office at 215 Federal Building in Topeka, on May 19. The officers of the Kansas Board are Major R. W. VanDeventer, a physician who practiced in Wellington prior to his entry into the Army, and Major H. J. Dixon, a member of the Infantry, whose home is in Kansas City, Missouri.

The Kansas Board is interviewing all physicians who call at its office and it is very desirous of assisting the Procurement and Assignment Program in this State in any way it can.

REHABILITATION PROGRAM

As was reported in the April issue of the Journal, the National Selective Service Headquarters is instituting plans in each state wherein certain rejected selective service registrants may be rehabilitated for military service through the provision of medical, surgical and dental treatment at government expense.

The Kansas Selective Service has in this connection forwarded the following information to the Society central office:

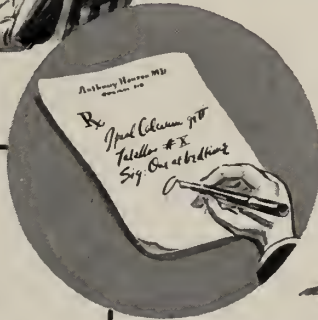
"We wish to obtain applications from the members of the medical profession to do this work in this State and would appreciate it if you will publish the paragraph found in the Journal of the American Medical Association, in the Journal of your State Association with the notice that if those who care to participate in this work will write a letter to the State Director of Selective Service, Topeka, Kansas, stating that fact, he will send out the proper application blanks to be filled out."

The Journal of the American Medical Association item referred to above is as follows:

"National Headquarters, Selective Service System, has announced that tests of a physical rehabilitation program, intended to make many registrants who were rejected because of minor physical defects fit for active military service, have been authorized in Maryland and Virginia.

Authorization of the rehabilitation programs in the two states marks the beginning of a long-planned nationwide physical rehabilitation campaign. When the results of these pilot tests are evaluated, a date for the inauguration of the national program will be set. Only those registrants whose disabilities are certified by the Army as being remediable will be eligible to undergo treatment. As one of the first steps in the Maryland and Virginia test programs, the Director of Selective Service of each state will submit to National Selective Service Headquarters lists of physicians and dentists qualified to correct physical defects of registrants. Physicians and dentists designated to render these authorized professional services will be paid by the federal government.

National Headquarters emphasized that any physician or dentist can apply to be designated to assist in the rehabilitation program. Physicians and dentists not already designated by registrants as their choice for dental or medical treatment, and other physicians and dentists who wish to take part in the program, may obtain the necessary application forms from their local boards."



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GROUP HOSPITALIZATION PROGRAM

The Kansas Group Hospitalization Service Association, Inc. has supplied the following information concerning its group hospital program, which is now being organized:

"The plans of the Kansas Hospital Service Association, Inc., are nearing completion. Within a few weeks any individual or head of a family may enroll, as a member of a group, for himself or for his family. Individual payments will be seventy-five cents per month. Family payments, regardless of number of children under nineteen years of age, will be \$1.50 per month.

Any individual or each member of a family belonging to this Blue Cross Plan may receive thirty days' free hospitalization plus certain extras such as operating or delivery room fees, drugs and dressings, and other benefits.

In proclaiming May 12 as National Hospital Day, Governor Ratner said; 'This year the Kansas Hospital Association has given us a special reason for pride in our State. Through their sponsorship, a program is being inaugurated by which families and individuals may lessen the burden of hospitalization expense. In these wartime days when our standards of living are threatened and every possible economy is necessary for the nation's welfare, their statewide group hospitalization plan will be of untold value to these in need of such service but unable to meet large emergency expenditures.'"

The members of the Board of Directors of the Kansas Hospital Service Association, Inc., are: Chancellor Deane W. Malott of the University of Kansas, Lawrence; Mr. Laird Dean of Topeka; Mr. B. L. Sheridan of Paola; Dean John Warren Day of Topeka; Mr. C. O. Wright of Topeka; Mr. J. C. Mohler of Topeka; Dr. O. O. Wolf of Manhattan; Mr. C. C. Cogswell of Topeka. Hospital representatives of the board are as follows: Mr. H. J. Andres of Newton; Dr. M. G. Sloo of Topeka; Miss Dorothy McMasters of Winfield; Rev. Emil Duchene of Concordia; Miss Zillah Leasure of Salina; Mr. W. M. Crosby of Topeka; Sister Mary Fidelis of Salina; and Mrs. John R. Stone of Topeka. Physician representatives who are members of the board are as follows: Dr. C. D. Blake of Hays; Dr. Leo V. Turgeon of Topeka; Dr. Charles C. Hawke of Winfield; Dr. John L. Lattimore of Topeka; Dr. Robert B. Stewart of Topeka; Dr. J. H. A. Peck of St. Francis; Dr. Floyd Taggart of Topeka and Dr. H. Penfield Jones of Lawrence.

COMPENSATION FEE SCHEDULE

Mr. Erskine Wyman, Workmen's Compensation Commissioner for the State of Kansas announced on May 1, that a new fee schedule has been adopted by that Commission for compensation work and that copies of the new schedule would be mailed to all physicians upon request.

A pamphlet has been published by the Commission in which is contained the new fee schedule, a synopsis of the Workmen's Compensation Law, suggestions for the rating of disabilities, suggestions for completing workmen's compensation forms and other comments and information.

The new fee schedule is different in a considerable number of respects from the schedule formerly used for this purpose. The new schedule was completed and approved in conjunction with the Society Committee on Industrial Medicine.

PRIZES

The following are the winners of the prizes at the annual golf and trap shooting tournaments held in connection

with the annual session held in Wichita on May 11, 1942.

CHAMPIONSHIP FLIGHT			
First low gross	J. V. Van Cleve Wichita	Nordstrom Trophy—Fitted Case	The Mennen Co.
Second low gross	E. S. Edgerton Wichita	Quinton-Duffen Trophy Sand- wich Tray	Kans. Med. Golf. Assoc.
First low net	W. M. Scales Hutchinson	Mead Johnson Trophy	Kans. Med. Golf Assoc.
Second low net	E. M. Sutton Salina	Electric Clock Winfield Acad. of Med. Trophy Sparklet Siphon	C. B. Fleet & Co.
FIRST FLIGHT			
First low gross	Paul Trimble Emporia	Pratt Co. Trophy Bathroom Scales	Kans. Med. Golf. Assoc.
Second low gross	L. J. Lattimore Topeka	Golf Club Helmets	Wm. S. Mer- rell Co.
Third low gross	H. P. Jones Lawrence	Sun Glasses	American Optical Co.
Fourth low gross	J. H. Schrant Hutchinson	Cigarettes	Philip Morris & Co.
Fifth low gross	W. K. Hobart Topeka	Cigarettes	Camel Cigarette Co.
First low net	J. J. Hvorka Emporia	Saline Co. Trophy Mix- ing Bowls	Kans. Med. Golf Assoc.
Second low net	Cecil Snyder Winfield	Reno Co. Trophy Insufflator	John Wyeth & Bros., Inc.
Third low net	J. W. Shaw Wichita	Surgical Sutures	Davis & Geck
	G. L. Ashley Chanute	Surgical Sutures	Davis & Geck
Fourth low net	W. D. Pitman Pratt	Cigarettes	Camel Cigarette Co.
SECOND FLIGHT			
First low gross	Clyde W. Miller Wichita	Cobean Trophy Thermos Bottle	Kans. Med. Golf Assoc.
Second low gross	George Gsell Wichita	Gift Journal Certificate	C. V. Mosby Co.
Third low gross	V. L. Pauley Wichita	Playing Cards	Kans. Med. Golf Assoc.
Fourth low gross	C. H. Dixon Wichita	Cigarettes	Philip Morris & Co.
Fifth low gross	G. G. Whitley Douglass	Cigarettes	Camel Cigarette Co.
First low net	L. S. Nelson Salina	\$5.00 Defense Stamps	Am. Hosp. Supply Corp.
Second low net	A. P. Cloyes El Dorado	Billfold	Kans. Med. Golf Assoc.
Third low net	G. E. Stafford Salina	Playing Cards	Kans. Med. Golf Assoc.
Fourth low net	H. R. Hodson Wichita	Playing Cards	Kans. Med. Golf Assoc.
Fifth low net	B. P. Meeker	Cigarettes	Philip Morris & Co.
THIRD FLIGHT			
First low gross	A. L. Ashmore Wichita	Fischer & Co. Trophy Sandwich Tray and Dish	Kans. Med. Golf Assoc.
Second low gross	R. R. Sheldon Salina	Baking Dish	Kans. Med. Golf Assoc.
Third low gross	R. H. Maxwell Wichita	Cigarettes	Camel Cigarette Co.
Fourth low gross	J. L. Wentworth Arkansas City	Cigarettes	Philip Morris & Co.
First low net	G. E. Milbank Wichita	3 Wilson Golf Balls	Lowe & Camp- bell
Second low net	C. F. Taylor Norton	Ice Collar	Kans. Med. Golf Assoc.
Third low net	Rohr. Sohlberg McPherson	Fitted Medicine Case	Zemmer Co.
Fourth low net	R. A. West Wichita	Hypodermic Set	Burrroughs- Wellcome
High Score	H. H. Loewen Wichita	Playing Cards	Kans. Med. Golf Assoc.
Most Eagles	N. L. Rainey Wichita	Golf Balls	Kans. Med. Golf Assoc.
KANSAS MEDICAL TRAP AND SKEET ASSOCIATION May 11, 1942			
High Over All	W. G. Gillett Wichita	Mead Johnson Trophy Billfold	Kan. Med. Trap & Skeet Assoc.
High Trap	R. E. Cheney Salina	Thermos Bottle	Kan. Med. Trap & Skeet Assoc.
High Skeet	L. A. Sutter Wichita	Hematological Set	Bard-Parker
Runner-up Trap	H. P. Jones Lawrence	Polariod Glasses	American Optical Co.
Third High Trap	O. C. McCandless Marion	Medical Kit	Sharpe & Dohme
Runner-up Skeet	G. B. Morrison Wichita	Electric Timer	General Electric

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	F. L. Loveland		Davis & Geck
	Topeka	Assorted Sutures	
	E. L. Vermillion		
	Salina		
	Howard Snyder	Cigarettes	Philip Morris & Co.
	Winfield		Camel Cigarette Co.
	W. E. Stone	Cigarettes	
	Norton		Philip Morris & Co.
	Murray C. Eddy	Cigarettes	De Vilbiss
	Hays		
	D. D. Vermillion	Atomizer	
	Goodland		
	C. B. Bell	Playing Cards	Kan. Med. Trap & Skeet Assoc.
	Pittsburg		
	J. W. Cheney	Playing Cards	Kan. Med. Trap & Skeet Assoc.
	Wichita		

Officers of the Kansas Medical Golf and Trapshooting Association elected, at the meeting of that organization held in Wichita on May 11, the following to serve during the next year: Dr. W. K. Hobart of Topeka as President; Dr. H. P. Jones of Lawrence, as Vice-President and Dr. Paul Trimble of Emporia as Secretary.

A. M. A. MEETING

The 93rd Annual Session of the American Medical Association will be held in Atlantic City, New Jersey, from June 8 to June 12, 1942. The scientific session will be open on June 9 and the various section meetings will commence on June 10. The House of Delegates will hold its first meeting on Monday, June 8.

Hotel reservations may be made through the Florence McCann, Convention Housing Committee, 16 Central Pier, Atlantic City, New Jersey.

Several railroads have advised the central office that they will be able to make definite travel reservations for the meeting, of the type desired. However, by reason of present conditions, travel reservations should be made as early as possible.

APPOINTMENTS

Governor Payne H. Ratner, announced on April 30, the re-appointment of Dr. C. E. Joss of Topeka and Dr. O. L. Cox of Iola, for four year terms each, on the Kansas State Board of Medical Registration and Examination.

INDIGENT PLAN

The Shawnee County Medical Society recently completed arrangements with the Kansas State Board of Social Welfare, the Shawnee County Board of Social Welfare and the city of Topeka, to institute a new plan for the provision of indigent medical care.

The plan is a complete service plan based upon the use of a rotating staff, at the city of Topeka clinic, for treatment of ambulatory patients and upon the use of specialists and other facilities for other types of service.

The plan will be financed by the county paying an amount of \$3.00 in the monthly budget of each relief client desiring to participate and by the client in turn paying that amount to the Shawnee County Medical Society.

The Shawnee County Medical Society opened a full time office in Topeka on May 1 to assist in the operation of the plan. The Director of the full time office is Mr. Ralph Callahan, who was formerly County Welfare Director of Riley County and who has had a large amount of experience with plans of this type.

INDUSTRIAL HYGIENE

The Kansas State Board of Health has recently issued the following information in regard to the industrial hygiene service available through that board:

"As a result of the war emergency, industrial employees are coming in contact with new materials, devices, and methods of operation. For maximum production, the health of the employee must be normal, but in order to help keep his health normal, phases of operations affecting health must be controlled.

In order to help the industries of Kansas solve such problem, the following engineering and chemical services are available (within limits) through the Industrial Hygiene Section of this Division, Lawrence, Kansas, without charge. A physician will be attached to the Industrial Hygiene Section after July 1, 1942.

INDUSTRIAL HYGIENE SURVEYS: Indicate potential industrial health hazards present in a given industry.

INDUSTRIAL HYGIENE STUDIES: Point out specific industrial health hazards, mainly for specific operations in an industry.

LABORATORY SERVICE: Chemical and microscopical analyses of the atmospheric conditions.

EDUCATIONAL SERVICE: Through correspondence, bulletins, pamphlets and illustrated lectures important information is provided industries on matters pertaining to industrial hygiene.

In addition to the above services, the University of Kansas, School of Engineering and Architecture is organizing, off the Campus, without charge, Safety Engineering classes in various cities. It is the purpose of these classes to promote industrial safety and to conserve manpower in war industries by training men for leadership in such programs. Information on safety classes can be obtained by directing communications to 109 Fraser Hall, Kansas University, Lawrence, Kansas."

LAND USE COMMITTEE

The following are excerpts from the minutes of the meeting of the Kansas State Land Use Committee, held in Manhattan on March 26-27:

"Group Hospitalization: The Health Committee at its last meeting adopted a resolution expressing interest and a probable desire to participate in a group hospitalization insurance program being sponsored by the Kansas State Hospital Association. A report was made to the Health Committee at the present session of the Committee that the Kansas State Hospital Association is making progress with its plans for the program; that an application has been filed for a corporate charter wherein the Kansas State Hospital Association would be authorized to offer hospitalization insurance policies of this kind; that other methods and procedures are being developed toward that end; and that it is hoped the plan can be submitted in detail at an early meeting of the Committee for further consideration and action.

Mileage Charges—The Kansas Medical Society was asked at a recent meeting of the Health Committee to consider the matter of physicians' mileage charges for medical services to farm families. Dr. Walter Stephenson of Norton, Chairman of the Medical Economics Committee of The Kansas Medical Society, and Dr. C. D. Blake, the President of that organization, reported to the Committee that the matter had been considered, and that the following resolution was unanimously adopted by the Council of The

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Kansas Medical Society at a meeting held on February 22, 1942;

The Council recommends to all Kansas doctors of medicine that mileage charges in connection with the provision of medical service to farm families should be eliminated; and that a method be submitted therefore wherein fees for farm medical service shall be based on the nature and extent of individual services rendered.

The Health Committee was very happy to endorse this recommendation. It feels that although mileage charges may not customarily exist today in the State of Kansas, farm families do prefer to pay their medical obligations on the basis above outlined rather than upon the arbitrary method of geographical location and distance, and that the above official action on the part of the Kansas medical profession is indeed a splendid example of cooperation and assistance to farmers as a whole and to the Committee.

It is of interest that the action herein taken is one of the first, if not the first, on this subject in the country.

Need for Physicians in the Military Forces—Versus Civilian Needs—A report was presented wherein the procurement and assignment program for physicians was described. The various aspects of that program seem to indicate that efficient plans have been made by governmental agencies and the medical, dental, and veterinary medical professions through which needed doctors of medicine, dentistry, and veterinary medicine may be retained for home service rather than be placed in military or similar duty. The Health Committee feels there is every possibility under this program for Kansas physicians to be placed in the form of service in which they can best assist the country, and it also feels that the program, as described, rather completely fills the recommendation on this subject recently adopted by the general committee.

Reports were given as to progress being made in the fields of tuberculosis control and indigent medical care—both of which have previously been the subject of consideration and recommendation by this Committee. The Health Committee feels that the progress reported in this regard is favorable and satisfactory.

A suggestion was made by Dr. C. D. Blake, President of The Kansas Medical Society, that the present program of the Committee on preventive medicine be extended to also include the furtherance of needed equipment facilities, and similar diagnostic aids.

Health—The Health Subcommittee has worked closely with several agencies in promoting health programs of benefit to the State. Of primary importance has been the Blue Cross Hospitalization plan which provides cooperative

hospital service to farm families as well as to town people. The Committee has been active in promoting the School Lunch Program and the Food Stamp Plan. It is working with The Kansas Medical Society in an effort to improve rural medical service and with Farm Security Administration Cooperative Medical Associations. This subcommittee has a very important task of coordinating the numerous rural health programs.

Preventive Medicine in Relation to Health—In view of the limited amount of information on the Medical Care Experimental Program of the Department of Agriculture and the diversity of opinion, the Committee does not feel justified in going on record for or against the program. The Committee recommends that agencies interested attempt to formulate a more workable plan and present it to the next State Agricultural Planning Committee meeting with a full explanation of same.

Since Morris County has made a study of the Medical Care Experimental Program of the Department of Agriculture and has signified their wish for more detailed information on the program, this Committee does not wish to stand in the way of such information, and recommends that the Morris County Planning Committee continue to cooperate with the Department of Agriculture in developing a definite plan to be presented to the State Agricultural Planning Committee before it is presented to the people of Morris County.

Progress with Recommendations made in November 1941—Each Extension group is including in their program a talk on Cancer Control and recommendation has been made to them that they arrange for a local or county meeting where a doctor can give them further information on this subject. All boys and girls in 4-H Clubs are checking their food habits as a step toward improving their nutrition and building their health."

As has been described in previous issues of the Journal the Kansas State Land Use Committee is an organization composed of prominent farm groups, farmers and other agencies and individuals interested in farm problems.

MEMBERS

Dr. W. J. Biermann recently returned to Wichita from Chicago where he had been doing post-graduate work at the Cook County Hospital.

Dr. L. B. Gloyne of Kansas City, has re-opened his offices in the Brotherhood Building in that city.

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COUNTY SOCIETIES

The members of the First Councilor District held a dinner meeting in Hiawatha on April 23, with the wives of the members as guests. The scientific program consisted of a symposium presented by Dr. F. C. Helwig, Dr. P. T. Bohan and Dr. M. G. Berry, all of Kansas City, Missouri. Dr. J. W. Randell, Councilor, presided at the meeting.

A meeting of the Cowley County Medical Society was held on March 24, at Winfield. Dr. Edward Hashinger of Kansas City, Missouri, spoke on "Hyperthyroidism" and Dr. F. A. Carmichael, Jr. of Kansas City, Missouri, spoke on "The Use of Vitallium Plates for Restoration of Skull Defects". At a meeting of the organization held on April 22, Dr. W. G. Weston of Arkansas City was elected as President to succeed Dr. Howard Snyder of Winfield who is now serving in the United States Army. Others officers elected were as follows: Dr. M. J. Dunbar of Winfield as Vice-President and Dr. H. A. Mercer of Arkansas City as Secretary-Treasurer.

The Douglas County Medical Society held an informal dinner meeting in Lawrence on March 31, honoring Major V. M. Auchard, formerly of Lawrence, and now serving in the Army.

The Golden-Belt Medical Society met in Junction City on April 2 in addition to the scientific program Dr. F. L. Loveland of Topeka discussed "The Procurement and Assignment Service Program." The following new officers were also elected at the meeting: Dr. E. Raymond Gelvin of Concordia as President; Dr. Myron Husband of Manhattan as First Vice-President; Dr. Robert Sohlberg of McPherson as Second Vice-President; and Dr. L. S. Nelson of Salina as Secretary. The next meeting of the organization will be held in Manhattan on July 2.

The Lyon County Medical Society held a meeting on April 7 at the Newman Memorial Hospital in Emporia. Dr. Wade Hampton Miller of Kansas City, Missouri, spoke on "Selection of Air Men and Maintenance" and Captain William A. Ong of Kansas City, discussed "Pilot Training."

The Pratt County Medical Society met in Pratt on March 27. Dr. Louis L. Robbins of Topeka spoke on "Psychiatry in General Practice". At a meeting of that society held on

April 24 in Pratt, Dr. Verne L. Pauley of Wichita discussed "Surgical Management of Gall Bladder Diseases".

A meeting of the Riley County Medical Society was held in Manhattan on April 29. Dr. Vernon Wikston of Topeka spoke on "Allergy". Dr. J. Willard Hanson of Manhattan was also elected Secretary of the society at the meeting to succeed Dr. Ruth Montgomery who is moving to Wichita.

The Sedgwick County Medical Society met in Wichita on April 7. Dr. Thor Jager of Wichita spoke on "History of Pathology" and Dr. J. H. Humphrey of Wichita discussed "The War in China" which talk was illustrated with motion pictures. A meeting of that organization held on April 21 was devoted to four case studies, with the members of the society conducting the discussion.

At a meeting of the Shawnee County Medical Society held in Topeka on May 4, Dr. John L. Latimore of Topeka spoke on "Blood Transfusion Methods, Reactions and Use of Serum".

The Southeast Kansas Medical Society held a meeting in Chanute on March 26. Speakers were: Dr. L. R. Pyle of Topeka who discussed "Important Points of Pre-Natal Care" and Dr. Howard Snyder of Winfield who spoke on "The Ambulatory Management of Fractures of the Lower Extremities."

The members of the Wilson County Medical Society and their wives attended a dinner meeting in Neodesha on April 6. Medical defense plans for that county were discussed and prepared at the meeting.

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At the April 21 meeting of the Wyandotte County Medical Society held in Kansas City, Dr. Louis Allen of Kansas City spoke on "Melanoma" and Dr. W. J. Feehan of Kansas City spoke on "Rupture of Supraspinatus Tendon". Decision was also made at the meeting, to provide physical examinations, free of charge, to all members of the volunteer civilian fire and police department, appointed in conjunction with the Civilian Defense Program in that county.

The Sisters of St. Joseph Hospital entertained the members of the Cloud County Medical Society at a dinner held on April 7, in Concordia. A motion picture on syphilis was shown by Dr. R. H. Reidel of Topeka, of the Kansas State Board of Health.

DEATH NOTICES

Dr. Spencer B. Dykes, 72 years of age, died March 10 at his home in Esbon. He was graduated from the Memphis Hospital Medical College in 1902 and was a member of the Jewell County Medical Society.

Dr. William C. Lathrop, 65 years of age, died on April 27 at his home in Norton. He was born on December 8, 1876 at Marion, Iowa and attended the Chicago Homeopathic Medical College from which he was graduated in 1902 and the University of Illinois, College of Medicine from which he was graduated in 1909. Dr. Lathrop was a member of the Northwest Kansas Medical Society, a member of the Kansas State Board of Health, and was the founder of the Norton Municipal Hospital.

Dr. John S. Fulton, 69 years of age, of Topeka, died on April 10 at the Veteran's Hospital at Wadsworth. He was born in Jefferson County on June 4, 1872, and was graduated from the College of Physicians and Surgeons of Kansas City in 1901. He was a member of the Shawnee County Medical Society.

Dr. Franklin Charles Stewart, 63 years of age, of Eskridge, died on March 27 at Emporia. He was born on July 18, 1878 at Palmer, Indiana and graduated from the Chicago College of Medicine and Surgery in 1905. Dr. Stewart was a member of the Wabaunsee County Medical Society.

ANNOUNCEMENTS

The Western Branch of the American Urological Association will hold its next meeting at the Hotel Del Monte, California, from June 22-24, 1942.

The twenty-first annual session of the American Congress of Physical Therapy will be held in Pittsburgh, Pennsylvania on September 9-12, 1942.

The Council for the American Association for the Study of Goiter has canceled its annual meeting which was to be held at Atlanta, Georgia on June 1-3, 1942.

KANSAS MEDICAL ASSISTANTS SOCIETY

The Third Annual Meeting of the Kansas Medical Assistants Society held in Wichita on May 11, had a registration of one hundred forty-five.

The members of the Sedgwick County Medical Assistants Society were hostesses at the convention and provided the following speakers on the program: Mr. J. E. McCurdy of Topeka, General Agent for the Medical Protective Company; Miss Opal Nichols of Topeka, Secretary to the Commissioner of Workmen's Compensation; Mr. Melvin E. Clark, President of the Wichita Retail Credit Association; Mr. Oliver Ebel of Wichita, Executive Secretary of the Sedgwick County Medical Society; Mrs. Birdell M. Roseberry of Wichita, representative of the American Red Cross; Dr. Forrest L. Loveland of Topeka, Chairman of the Kansas Committee on Procurement and Assignment for Physicians; Miss Evelyn Hunter of Wichita, Councilor of the Wichita Public Schools; and Mr. C. G. Munns of Topeka.

The following new officers were elected at the business meeting: President, Mrs. Florence Linton, Topeka; President-Elect, Mrs. Edna Nichols, Hutchinson; Vice-President, Mrs. Gretchen Moddrell, Wichita; Recording Secretary, Mrs. Marjorie Euler, Topeka; Treasurer, Miss Irene Miller, Emporia; Corresponding Secretary, Mrs. Virginia Kistler, Topeka; Councilor, First District, Miss Pearl Scott, Kansas City; Councilor, Fifth District, Miss Margaret O'Rourke, Dodge City.

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AUXILIARY

PRESIDENT'S MESSAGE

Our annual convention is now only a memory, but a very pleasant one. Although transportation facilities were somewhat curtailed, we had a large Auxiliary registration—over 200. I am sure everyone who attended the convention gained some worthwhile information and enjoyed the entertainment provided by the Sedgwick County Auxiliary. The highlight of the meeting, of course, was meeting our National President-Elect, Mrs. Frank Haggard of San Antonio, Texas. We know the National organization will be in capable hands during the coming year for her ability is apparent. Her gracious southern charm made friends of all who met her.

Mrs. Haggard, Mrs. W. Y. Herrick and our Advisory Chairman, Dr. C. Omer West, all urged our active participation in Auxiliary work for the coming year. There will be countless opportunities for us to serve the public in the matter of health education. Let us not pass up any of them. I am sure that the stress of our National emergency will only serve to knit our organization more firmly together.

Mrs. C. Omer West.

NEW OFFICERS

President-Elect—Mrs. E. E. Tippin, Wichita.
First Vice-President—Mrs. A. C. Flack, Fredonia.
Second Vice-President—Mrs. Wilfred Cox, Wichita.
Recording Secretary—Mrs. H. L. Regier, Kansas City.
Treasurer—Mrs. E. N. Robertson, Sr., Concordia.
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Bulletin—Mrs. L. B. Gloyne, Kansas City.

AUXILIARY MEETING IN BRIEF

Mrs. Frank Haggard of San Antonio, Texas, National President-Elect of the Women's Auxiliary to the American Medical Association, was the feature speaker at the State meeting held in Wichita on May 11-13. Mrs. Haggard is a charter member of the National Auxiliary, was the President of the Texas Auxiliary in 1933, and President of the Auxiliary to the Southern Medical Association in 1934. She is active in legislative work in her home state and a member of several state and national committees.

Other speakers at the Auxiliary meetings were: Dr. C. D. Blake of Hays, Dr. Henry N. Tihen of Wichita, Dr. C. Omer West of Kansas City and Mr. Clarence Munns of Topeka.

There was some two hundred Auxiliary members and wives of members of The Kansas Medical Society registered during the meeting. The Sedgwick County Auxiliary supervised the arrangements and the program for the events, which was well organized and conducted.

AUXILIARY NOTES

The Women's Auxiliary to the Sedgwick County Medical Society held a luncheon in Wichita on April 13, with Mrs. L. A. O'Donnell of Wichita as hostess. Mrs. Jerry Daniels of Wichita spoke on "My Experiences in Pearl Harbor". As a part of the war relief program the Sedgwick County Auxiliary has contributed 400 garments to the Red Cross, and bundles to the Committee for Relief of Disaster in that county.

The Shawnee County Auxiliary entertained the husbands of its members with a picnic held on May 21, in Topeka. Mrs. John L. Latimore of Topeka was in charge of the program.

The Marshall County Auxiliary entertained with a dinner meeting in Marysville on March 12. Mrs. R. L. McAllister of Marysville, gave a talk on China.

Dr. W. W. Bauer of Chicago, Director of the Bureau of Health Publicity of the American Medical Association was a speaker at four meetings in Salina on May 6. Dr. Bauer talked to the Chamber of Commerce of Salina, the High School, Marymount College, and the Saline County Women's Auxiliary, who sponsored his appearance in Salina.

The Neurological Hospital provides a complete diagnostic service for psychiatric and neurological patients, and utilizes modern methods of therapy such as insulin and curare-electric shock. Treatment programs are based upon total patient therapy from the standpoint of internal medicine, surgery and the other specialties, as well as the psychiatric and neurological symptomatology.

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FACTORS TO BE CONSIDERED IN THE CONSTRUCTION OF THE DIET OF THE OLDER CHILD*

Alan Brown, M.D.

E. Chant Robertson, M.D.

Toronto, Canada

The growing child and the pregnant and nursing mother need proportionately more of the dietary essentials than the rest of the population. As Sebrell has aptly put it, children are more sensitive to their nutritional environment than unencumbered adults. Therefore for the optimum growth, development and health of a child, it is extremely important not only to provide diets which contain sufficient amounts of all the essentials, but also to see that they are taught to eat them. In some conditions, for example coeliac disease, the child is unable to utilize some of these essentials in the normal manner, but recent discoveries which will be described later have disclosed very satisfactory ways of overcoming their handicaps and meeting their nutritional needs.

It is common knowledge that the complete lack of vitamin C for at least three to four months results in the development of scurvy in an infant. A relatively small amount of vitamin C, about seven mgms. per day (two teaspoonsful of orange juice), will prevent the development of this disease, but much larger doses, something in the neighborhood of thirty mgms. (two ounces of orange juice) per day are recommended by the Committee on Nutrition of the National Research Council of Washington, as the optimum daily amount for normal infant health. A simple test carried out on guinea pigs illustrates this point. If a young guinea pig, approximately 300 grams in weight, is given a scorbutic diet plus four cc. of tinned tomatoes daily, his growth proceeds at a normal rate and at the end of eight weeks he weighs about 470 grams. If another pig of the same age and weight is given the same scorbutic diet but

with only one-quarter as much of the tinned tomatoes per day (i.e. one cc.) he loses weight instead of gaining and at the end of the eight weeks he is emaciated and generally in poor condition. However he has not developed scurvy. There was sufficient vitamin C in his small daily dose of tomato juice to prevent him from developing scurvy, but not enough for optimum growth and health. The same situation holds true for most, if not all, of the other vitamins. A relatively small amount will prevent the development of the dramatic deficiency diseases but much more than that amount is needed for optimum, or in other words, the best possible nutrition.

The dietary surveys which were recently carried out in Toronto by the Canadian Council on Nutrition¹ have shown even among families having incomes ranging from \$1500 to \$2400 a year, that many of the dietary essentials are eaten in insufficient amounts for the best of health, growth and vigour. Our eating habits are similar to yours and there is little doubt but what similar conditions would be found here. What were the food essentials that were most frequently eaten in insufficient amounts? Vitamin B₁ and vitamin C were the most frequently and markedly deficient. The teen-age girls ate too little calcium also. The iron needs of the growing children were often not met and the same holds true no doubt for vitamin D, iodine and riboflavin. It would be well therefore to discuss these essentials in more detail than the others which are much less seldom lacking.

Modern day diets because of our fondness for white flour products and sugar, are more apt to be low in vitamin B₁ or thiamin than any other dietary essential. They are also low in pyridoxine (vitamin B₆) which as a rule occurs in the same foods as thiamin. On the other hand, the ten per cent or so of the population who use whole grain cereals and whole wheat bread do not suffer from this lack of the B vitamins because these products contain generous amounts of them. These foods also contain valuable amounts of iron, but all these essentials are found in the bran and germ almost exclusively and these are the very parts that are discarded in the making of white flour. To be exact they aren't actually discarded, for the bran and germ are sold to

*Presented at the 83rd Annual Session of The Kansas Medical Society, Wichita, May 12, 1942.

the farmer as pig food. It is not surprising therefore that pork is a rich source of the B vitamins. When we eat white flour, the pig gets the best part of the wheat.

The whole grain products are numerous—they include whole wheat flour, rolled oats or wheat, wheat flakes, cracked wheat, rye flour, brown rice and the pre-cooked shredded whole wheat products. It is worth knowing at this time, when it is essential that we all reduce our spendings on inessentials, that the bulk home-cooked whole grain porridge stuffs cost approximately one-fifth as much per serving as the pre-cooked packaged cereals. Incidentally the toasted flaked cereals contain no vitamin B₁ at all. Even toasting bread destroys about twenty per cent of its content of this vitamin. The whole grain products are more laxative than the highly purified whiter cereals, but in normal individuals this does not cause trouble. Wheat germ, as you would expect, is extremely rich in the B vitamins. It is an excellent plan to incorporate at least one tablespoon of wheat germ in the daily diet. This can be added to cooked cereals, preferably shortly before serving, or in amounts up to twenty-five per cent to white flour which is to be made into muffins, tea biscuits, etc. When cooked in this way, some twenty per cent of the thiamin is destroyed, but even after that loss a great deal still remains. One tablespoon of wheat germ contains approximately eighty International Units of vitamin B₁, which is almost one-sixth of our total daily requirements.

Vitamin B₁ plays many roles in the body. It is necessary for normal growth—although it is not unique in this regard. When diets low in this vitamin are eaten anorexia and intestinal hypotonia frequently occur. It has also been shown that when the diet is very low in this factor, the body is unable to completely metabolize carbohydrates. Instead of being broken down to CO₂ and H₂O, they stop at the pyruvic acid stage. There is evidence that this accumulation of pyruvic acid is harmful, and of course it is plain that under such conditions the body is wasting some of its food. Several investigators have demonstrated clearly that individuals living on low vitamin B₁ dietaries lack physical energy, are quickly fatigued and suffer from mental depression and apathy.

As it is apparently impossible to persuade the English speaking races to use more whole wheat bread, as the British found after an extensive and clever advertising campaign during the early part of the war, other expedients have had to be used in order to increase the consumption of the B vitamins. In the United States and Great Britain you have been fortifying white flour with one, or it may be two or more of these factors. Another solution to this prob-

lem has been developed in Canada as the result of cooperative research carried out by the Nutritional Research Laboratory of the Hospital for Sick Children of Toronto, by the Dominion Departments of Agriculture, and Pensions and National Health, of Ottawa, and by some of the milling companies.² Without the necessity of buying new milling machinery a simple process has been devised whereby a white bread can be produced which contains practically as much of the B vitamins and probably also as much iron as the so-called whole wheat bread, which always contains at least one-third white flour. This is because the new type of white flour contains more of both the aleurone (sub-bran) layers and the germ. It is now generally available in Canada under the name of "Canada Approved Vitamin B White Bread and Flour". By this method a large fraction of all the B vitamins and minerals in the whole wheat are retained. In fortified white flour, practically all of the B vitamins and minerals are removed and then one, or at most three, are added again.

Other good sources of the B vitamins are liver, kidneys, pork, eggs, vegetables (especially the legumes and green vegetables) peanut butter and milk. There are four members of the B complex that are now known to be essential for human health, namely thiamin or vitamin B₁, riboflavin or vitamin B₂, nicotinic acid and pyridoxin or vitamin B₆. Some of the above-mentioned foods are richer in some of these vitamins than others. Milk is a particularly valuable source of riboflavin. In fact unless a pint of milk is taken daily it is very difficult to meet our needs for this factor. This vitamin is readily destroyed by light, so that bottles of milk should not be kept in a light place. Of all these foods, the whole grain products and liver are probably the most neglected. You would be wise to urge your patients to take one serving of a whole grain cereal, preferably fortified with wheat germ, per day; to use only whole wheat or the new vitamin rich white bread and also to serve liver once a week. Other foods containing whole wheat flour should be recommended also. In many cases it will be necessary to train the children to eat these foods. A conservative estimate of the daily needs of children and unencumbered adults is about 500 International Units of vitamin B₁ per day. (The Committee on Food and Nutrition, National Research Council, United State of America, recommends for children one to twelve years, 200-400 International units; over twelve years and adults, 400-766; pregnancy and lactation 600-766). If the individual takes one and one-fourth pints of milk, four ounces beef, four ounces cooked potatoes, four ounces vegetables (average of six common vegetables), six ounces of fruit (average of three common fruits), he receives in this fraction of his diet

about 300 International Units. A half cup of cooked rolled oats adds fifty-five units more, a tablespoon of wheat germ another eighty units, and four slices of whole wheat bread about 100 more, giving a total of 535 International Units. If however, the individual chooses cornflakes or farina for breakfast and uses only white bread, he will obtain only about 325 International Units per day. Further it is known that the needs for vitamin B₁ go up as the non-fat calories in the diet increase.

It is possible that in your country where citrus fruits and their tinned juices are produced in such large quantities, your growing children will be better provided with vitamin C than ours. It is recommended by the Committee on Nutrition of the National Research Council of Washington, that children from one to twelve years of age receive thirty-five to seventy-five mgms. of this vitamin per day (two, increasing to five ounces of orange juice), and that those over twelve and also adults, receive from seventy to 100 mgms. daily (five to seven ounces of orange juice). Fresh or tinned citrus fruit juices are about equally rich in vitamin C and contain approximately fifty mgms. in three and one-half ounces. Work that has been carried out under the direction of Drake⁴ in our laboratory has shown that there is no appreciable decrease in the vitamin C in the first forty-eight hours after the can is opened.³ Tomatoes or tomato juice contain only about two-fifths as much C as the citrus fruit juices. Raw cabbage and the other members of the cabbage family are also rich in C, providing some sixty mgms. in three and one-half ounces (that is in about one cup). Strawberries, raspberries, currants and canteloupe are also good sources of this vitamin. Most of the green vegetables and turnips and potatoes contain valuable amounts also. To conserve the maximum amount of this vitamin the foods should be cooked for the minimum length of time and in the least amount of water possible; the water should always be used in some way. Unfortunately apples, pears, peaches and grapes are low in vitamin C. Pineapple juice contains about one-quarter as much as orange juice and apple juice only about one-fiftieth as much.⁴ In order to get 100 mgms. of vitamin C per day, generous amounts of the foods rich in C are needed. There is good evidence that orange juice and tomato juice contain other antihemorrhagic principles in addition to vitamin C.

About eighty per cent of the calcium in a normal child's diet comes from milk or cheese. Milk of course should provide most of it. It is generally believed that children under twelve years of age retain the maximum amount of calcium if their intake is about one gram per day. This is provided by one-quart of milk (thirty ounces) or four ounces of

cheese. It seems likely that the rapidly growing older child should receive about fifty per cent more calcium per day. Many of these children do not take that much, partly because of the appeal of the ubiquitous soft drink and partly because of the girls' fear of becoming fat. Our teen-age girls are frequently short of calcium.

If the child is given one regular daily dose of one of the fish liver oils or some other source of vitamin D during the winter, he is able to use the calcium and phosphorus in his meals more economically than when this vitamin is lacking. Work carried out in Toronto by Tisdall and his associates has shown that vitamin D is a factor in the prevention of dental decay.⁵ Two groups of children ranging in age from five to fifteen years were observed over a period of one year. The diets in both cases were exactly the same, with the exception that the one group received additional vitamin D daily. X-rays were taken and instrumental examinations of the teeth were made without any knowledge as to which group the children belonged. When the examinations were completed the results were tabulated and it was found that the number of markedly progressive cavities and the number of new cavities were twice as frequent in the children who did not receive an adequate supply of vitamin D as in those who did. This is evidence of the need of vitamin D past the age of infancy. If it is not possible to expose children to sunshine throughout the year, we strongly recommend that some vitamin D be administered not only during the age of infancy but throughout the whole of childhood.

Our knowledge of the iron requirements of the child is in a state of transition. The excellent work of Sherman done many years ago indicated that about fifteen milligrams of iron were necessary daily for the growing child. However, work done in Wisconsin and by Summerfeldt⁶ in our department shows that we cannot simply consider iron in terms of the total amount in the food. We have found that there is a marked variation in the availability of iron in different foods. For these reasons in the future it will be necessary to consider iron not only from the standpoint of the total iron content of the foods given, but from the standpoint of the availability of the iron administered. Vegetables, especially the legumes and green vegetables, fruits, whole grain cereals, liver, kidney, meat, eggs and molasses are our richest sources of iron in food.

The third mineral element which requires special attention in regard to its administration in our part of the country is iodine. The chief source of iodine is sea-food, but due to our distance from the sea we have to take special measures for its incorporation

in the diet. This is done through the administration of iodized salt.

Thirteen of our dietary essentials are minerals, but provided sufficient calcium, iron and iodine are eaten in our foods, the other ten minerals will be present in adequate amounts also.

Vitamin A is present in many foods such as whole milk, cream, butter, eggs and liver; and carotene, which our bodies can convert into vitamin A, is present in the coloured vegetables. Actually we can change only about forty per cent of the carotene that we ingest into vitamin A, but the green and orange vegetables are so rich in this substance that they usually constitute the major source of our vitamin A. As a general rule the more orange or green the vegetable, the more vitamin A value it has. Carotene is a bright orange substance but in the green vegetables this colour is masked by the green chlorophyll. It is recommended that two vegetables besides potatoes be eaten daily. The raw and coloured ones are especially valuable. Vitamin A is found in such a variety of foods, that a deficiency of it is very rarely encountered.

We have obtained no evidence that the average Canadian child receiving a diet at all reasonable suffers from a lack of protein. It is usually considered that fifteen per cent of the calories supplied should be in the form of protein, and fifty per cent of this protein requirement should be grade A protein, that is, protein obtained from such foods as milk, meat, fish, eggs and cheese. The grade A protein requirements will almost be fulfilled if the child receives thirty ounces of milk daily.

If the child receives thirty ounces of milk daily containing from 3.5 to four per cent fat, along with one ounce of butter, his fat requirements for normal nutrition will be fulfilled.

We have never found any evidence of a child receiving a diet containing too small a percentage of carbohydrate. The ease with which we obtain purified carbohydrates in the form of sugars and highly milled flours accounts for this. In fact the greatest error which we find today is an excess of purified carbohydrate. In some diets, from thirty to fifty per cent of our calories are in the form of purified flours and sugars, which as a result of their purification are lacking in most of the minerals and vitamins.

It is recommended that for normal children the diet contain daily: (1) Approximately one quart (thirty ounces) of milk; (2) One generous serving of a food rich in vitamin C, i.e. orange or grapefruit juice, tomato juice or raw cabbage; fruit exclusive of jam at another meal. Two vegetables besides potato, including coloured or raw vegetables. (3) One serving of a whole grain cereal or porridge

stuff, preferably with wheat germ added. Only whole wheat or vitamin rich white bread should be used. (4) One serving or more of meat, fish, egg or fowl. Eggs three or four times a week or oftener; liver or kidney once a week. (5) Use iodized salt exclusively. (6) One regular dose of a good source of vitamin D during at least the six colder months of the year.

COELIAC DISEASE

No discussion of the nutritional disturbances of childhood is complete without reference being made to coeliac disease and its allied conditions. While coeliac disease begins in infancy, usually toward the end of the first and during the second year of life, it usually continues into the childhood years and frequently presents a major nutritional problem up to ten or twelve years of age.

Coeliac disease was originally described by Samuel Gee in 1888 as a nutritional disturbance characterized by generalized body wasting, protuberant abdomen and the passage of large, foul-smelling, greasy stools. Investigations into the disturbed physiology of coeliac disease revealed that a defect existed in the absorption of both fat and carbohydrate from the intestine. The unabsorbed fat in the stool is responsible for the greasy, oily appearance and the unabsorbed carbohydrate for the bubbly, frothy character which appears at times. The proteins of the food alone are absorbed in normal fashion.

Gee⁷ considered coeliac disease to be a definite clinical entity due to some single undetermined cause. As investigation of the condition proceeded, however, it became apparent that several different underlying conditions could be responsible for the generalized wasting, protuberant abdomen and characteristic stools which had been considered characteristic of the disease.

Largely due to the interest and study of this condition by the late Kenneth D. Blackfan of Harvard, a new concept of the disease began to appear. Blackfan⁸ recognized the multiple etiology of the condition described as coeliac disease and suggested that an individual showing the characteristic clinical evidences should be labelled as presenting the coeliac syndrome of symptoms. He noted that in a certain number of these patients the disease came on very shortly after birth, was very severe, often accompanied by evidences of chronic pneumonia and almost invariably resulted in death at an early age.

A generalized fibrosis of the pancreas with obstruction and dilatation of the pancreatic ducts into cyst-like spaces was found in these patients when they came to autopsy. Andersen of New York perfected a viscosometric test by which duodenal contents could be analysed for activity of pancreatic

enzymes. Using this test it became possible to diagnose these cases of fibrosis of the pancreas during life since these cases were invariably accompanied by a gross reduction or complete absence of pancreatic lipase, amylase and trypsin. Here then, was the first attempt at a classification of the conditions thrown together by Gee under the name of coeliac disease. These patients became known as individuals suffering from a coeliac syndrome of symptoms secondary to fibrosis of the pancreas.

The second group to be recognized as a clinical entity were infants in whom the symptoms of the coeliac syndrome began after an infectious process had been present for some weeks. It was demonstrated that in these cases alleviation of the symptoms would occur when the infection was removed. There seems little reason to believe that any one type of infection is likely to preface the coeliac syndrome of symptoms. Repeated acute infections, or lower grade continued subacute or chronic infections of the nasopharynx, ears, kidneys, have all preceded the development of the characteristic physical signs and symptoms.

A third group of cases was found to occur due to certain intestinal anomalies usually associated with a partial obstruction of the small bowel. These were relieved only by operation.

A fourth group was seen occasionally in infants suffering from enlargement of the mesenteric glands causing partial obstruction to the intestine. The total of these four groups, however, remained a small percentage of the cases presenting the coeliac syndrome of symptoms. The remainder, in whom no underlying cause can be recognized, are considered to be suffering from primary coeliac disease. It is primary coeliac disease which is most likely to present a severe problem in childhood.

In the past few years comprehensive studies of the pathogenesis of primary coeliac disease have taken place. It was known that two defects occurred—in carbohydrate metabolism and in fat metabolism. Crawford in 1938⁹ demonstrated that the defect in carbohydrate metabolism was due to defective absorption. May & McCreary¹⁰ in 1940 showed that these patients with primary coeliac disease showed abnormal gastro-intestinal motility. They were able to demonstrate a delayed emptying of the stomach and impaired segmental peristalsis in the jejunum and ileum. They found that the defect in absorption of carbohydrate varied with the degree of change in intestinal motility and when the intestinal motility was returned to normal by artificially stimulating peristalsis (with mecholyl) the absorption of carbohydrate could be returned to normal.

When these same investigators¹¹ studied the defect in fat metabolism they were able to show that

it, too, was due to a defect in absorption from the intestinal tract. Returning the segmental peristalsis of the gastro-intestinal tract to normal did not, however, improve the ability of these patients to absorb fat as it had carbohydrate. In systematic fashion all of the substances physiologically necessary for the absorption of fats were given to these patients with coeliac disease and their ability to absorb fat measured. Excess bile salts, pancreatic extracts, previous emulsification of the fat, mecholyl, were all added simultaneously without any improvement in the ability of these patients to absorb fat from the intestine.

Finally because of the fact that the picture of abnormal peristalsis in the intestine in coeliac disease resembled that found in vitamin B complex deficient animals a crude source of the B complex of vitamins was given by mouth to certain of these patients. The response on the part of certain of the patients was dramatic—their ability to absorb fat improved rapidly, their intestinal motility and ability to absorb carbohydrate returned to normal.

The cases of primary coeliac disease whose symptoms were mild responded most markedly to this form of treatment; the more severe, longer standing cases responded little or not at all. Reasoning that because of the defect in absorption these patients were not receiving adequate amounts of vitamin B, the investigators began the use of intra muscular injections of a crude source of vitamin B complex and crude liver extracts on alternate days. In all cases a response to this form of therapy occurred; in some the response was dramatic while in others it was much slower but none the less evident. It has been found necessary to give intramuscular injections for a period of about three weeks in most cases following which the oral administration of a crude source of the B complex of vitamins in large doses will usually permit improvement to be maintained. Usually a full diet can be safely given the patient from the time of the completion of the intramuscular injections. The diet should be broadened gradually during the period when the injections are given.

It has been shown that the presence of an acute infection with fever interferes seriously with this form of treatment and causes gross set-backs in the improvement of the patients treated. Removal of all foci of infection may well become a very necessary part of treatment.

This work is still far from complete and will be until the active agent or agents in the B complex of vitamins is discovered and obtained in a highly concentrated or crystalline state. It gives promise, however, of eradicating coeliac disease from the list of nutritional disturbances of childhood.

THE INTRODUCTION OF SOLID FOODS

It is important not only for the health of the infant, but also for the establishment of good eating habits that the mother should understand in detail how to introduce solid foods into his diet.¹² Milk alone is adequate for nutrition for only the first month of life. After that time the scurvy and rickets-preventing vitamins must be added in the form of citrus or tomato juices and fish liver oils. The solid foods, which should be started at from three to five months of age, provide other nutritional essentials, particularly iron which prevents the development of nutritional anaemia. It is true that certain cereals, which are the first foods introduced, can be tolerated by an infant as young as one month of age, but we believe that this is not wise. It seems probable that the too early introduction of solid foods may result in digestive disturbances later in infancy and childhood. Therefore, it is recommended that you play safe and delay the starting of cereals until between three to five months. No harm will be done by this precaution, and much subsequent trouble may be avoided.

Cereals: When the solids are begun, the feeding interval should not be altered. On the first day the child is offered one teaspoonful of the cereal chosen, which has been mixed up with the formula, or water if the child is breast fed, until it is porridge-like in consistency. It should not be thin or gruel-like. The cereal is offered to the child before he is given his milk feedings. It is important to start with only one teaspoonful because the texture, flavour and consistency of the cereal are entirely new to the child. He cannot swallow this new food by the sucking motions which he has used up to that time. The mother has to train the child to swallow the cereal. Many infants will spit it out for some days. It may take two or more weeks of training before the infant becomes resigned to the new food. On no account should the mother sympathize with the child and stop giving the cereal just because the child obviously dislikes it. If the child absolutely refuses to take the cereal or any of the other foods that are introduced later, the mother should take the food away after an interval of twenty minutes and she should not give him his milk which he likes. In the interval until his next feeding nothing should be given but boiled water. Usually the child will eat the cereal with avidity after such an enforced fast. This same method may have to be used later on if the child refuses to feed himself when he should be learning to do so. If the child refuses the next feeding the mother should consult her physician before starving him longer.

If the child refuses to take the cereal, the mother should not become angry or disturbed, hard though

this may be to avoid. On no account should the child be shouted at because at a surprisingly early age, the infant enjoys the commotion which his refusal provokes.

Once the infant has been taught to take the cereal in small quantities, it can be gradually increased according to his needs until two to four rounded table-spoons (as prepared for consumption) are given at his 10:00 a.m. and 6:00 p.m. feedings.

As to the choice of cereals. The cereals of course provide additional calories but it is best to choose one that is rich in vitamins and minerals as well. Mead's Cereal or its pre-cooked form, Pablum, meet this need admirably. They contain farina, oats and corn with the addition of the following ingredients which are rich in vitamins and minerals, namely wheat germ, dried brewer's yeast, machine dried alfalfa and edible bone meal. Extensive tests both in vivo and in vitro have shown that Pablum is better digested than ordinary cereals which have been cooked four hours. Apart from the cereal mixtures there are two other types of cereals available. The first are the highly purified white cereals such as farina, which are non-laxative but very low in vitamins and minerals. The others are the whole grain cereals such as rolled oats or rolled wheat, which though richer in the vitamins and minerals than the highly refined white cereal, are usually too laxative for young infants because of their bran content. Cereals should be cooked from one to four hours.

Bread: After the child's first tooth has erupted he should be given rusks, bread dried in the oven, or hard non-sweet biscuits to chew. These foods should not be so crisp that they break up when they are bitten.

Eggs: Egg yolk should be added at the 2:00 p.m. feeding from the age of six months on. Because of the possibility of allergic reactions the mother should give a very small amount, say one-fourth teaspoon or less, on the first day. If this causes no trouble the amount should be gradually increased until a whole egg yolk is given. The eggs may be coddled, soft-boiled or hard-boiled and mashed. At the age of one year whole egg may be given, either as such or incorporated in custards, etc.

Vegetables: The green or root vegetables may be given at the 2:00 p.m. feeding from the eighth month on. The choice should be made from the following vegetables—carrots, chard, green peas, green lima beans, fresh asparagus, string beans, young beet greens and cooked lettuce. Spinach should not be used overgenerously as it is nutritionally inferior to most of the other greens. These vegetables, although they are low in caloric value, are very valuable sources of many of the vitamins

and minerals, especially iron. They should be cooked only until tender, in the minimum of water and should be sieved until the child is two years of age. From then on, mashing is sufficient. The small amount of cooking water should be mixed with the vegetables. In cooking greens, the water left on them after washing is sufficient for cooking them. When the child reaches twelve months of age, squash, celery, beets, cauliflower and kale may be added to his diet list. The child should be fed the vegetables singly so that he becomes accustomed to their individual tastes. They too should be started in small amounts and then gradually increased. It is especially important to train children to eat a good variety of vegetables. The average child likes them the least of all his foods. Baked potato is also valuable, but must not take the place of the other vegetables. Canned sieved vegetables are equal if not superior to the home-cooked ones.

Fruits: Applesauce or prune or apricot pulp may be added to the supper menu from the tenth month on. Well ripened banana, as shown by the presence of brown patches on the skin may be served raw if it is thoroughly mashed with a fork. After the first year baked apples, stewed pears and peaches and scraped raw apple may be included in the diet.

Meat and fish: Scraped beef should be added in the latter part of the first year. (This is prepared by scraping lean round steak across the grain with a sharp spoon or a dull knife.) The meat so obtained is then made into a small patty, which is lightly cooked on both sides under a broiler or in the upper part of a double boiler over hot water. Later broiled, stewed or roasted chicken or liver may be added. These foods should be cut up fine before being fed. Boiled, steamed or baked non-oily fish such as cod, haddock or the fresh water varieties may be given once or twice a week. The fish of course is carefully boned and broken up into small pieces before it is given to the infant.

Prohibited Foods: The following foods should not be given to young children: Greasy or highly seasoned foods; fried foods with the exception of crisp bacon; veal, pork, corn or cucumbers; fresh bread or breadstuffs; pastry, cake or rich cookies; ice cream. Coffee or tea should never be used, partly because of the caffeine that they contain, but also because they replace milk which is particularly valuable to the child. Nuts, because of their high fat content, are hard to digest and there is always the danger of aspiration. They too should be forbidden. Candies as they are a concentrated source of calories and also because they have a high satiety value, should not be allowed. They take away the child's appetite for his meals, which are rich in vitamins

and mineral-containing foods. The amount of sugar commonly used in cooking is permissible, but sugar should not be added to cereals or fresh fruits. If the child is not given overly sweet foods, he will not demand them.

ANOREXIA

One should not end a discussion of this nature on the feeding of the older child without referring to the time-worn condition of anorexia which is unfortunately still with us. I would simply like to reiterate the remarks made by Brennemann of Chicago¹³ some years ago. In 1921 he wrote "The child that will not eat represents probably ten to twenty per cent of children in private practice between the second and fifth years inclusive, with a lesser incidence in the first year." Some years later he said: "Now anorexia is not an occasional occurrence, an isolated phenomenon in childhood; it is the rule in that very stratum of society in which mothers are lying awake planning a gospel diet and the most effective way of administering it. The lowest estimate of its incidence in private practice, that I know of, is fifty per cent. A scientific survey in a university neighborhood and a paediatrician with a large office practice have placed it at eighty and eighty-five respectively. A prominent paediatrician recent said that he had 'paid for his house with anorexia.'

"Every paediatrician knows these things to be true, and he also knows that they have nothing to do with hypochlorhydria, anaemia, tonsils, vitamin B or body build. The purely psychologic cause becomes evident when it is found that such anorexia occurs only in the home, and is cured rapidly and almost unfailingly when the child is sent to a ward in a hospital without any change in the food.

"The nutritional results of rebellion against forced feeding are still obvious on all sides, although there are encouraging signs of improvement. The healthy child who will not eat is, ipso facto, a behaviour problem, numerically the greatest of all, and as a factor in the pathogenesis of further disturbances in behaviour, probably second to none. One cannot fruitlessly nag, tease, cajole, wheedle, spoofer, beg, scold, bribe, threaten, punish, force, weep, or pretend to weep, or indulge in all kinds of monkey-shines, from playing the victrola, beating a drum, turning on the radio, singing a song, telling a story or showing a picture book to dancing a jig in order to get a child to eat—all stereotyped occurrences, without admitting failure and without losing nearly all of that wholesome spontaneous discipline that alone leads to a normal behaviour reaction." As Brennemann¹⁴ says:

"If propaganda so simple, concrete and tangibly

physical can produce such a volume of abnormal behaviour, what may one expect from a lay interpretation of the profusion and confusion of psychiatric literature, practice and exposition that is being poured out in ever increasing amounts? Mothers are unquestionably becoming psychiatrically minded. If there were only one wholly sane, simple and satisfying book on the subject, it would be a Godsend. But when one new book or two or three appear each year, to say nothing of special magazines, when every newspaper and magazine has a columnist or two culling from one authority and then from another; when those parents who elect themselves to educate other parents meet in annual convention with a galaxy of speakers that reminds one of the annual display of grand opera stars; when I.Q.'s and B.M.R.'s are being swapped at afternoon teas and bridge parties, and sex is discussed as freely as tonsillitis or the "flu"; when the radio slips in a ten minute talk on "Mental Health and How to Maintain It" hemmed in on both sides by jazz; when in other words, not simple, easily graspable, objective things such as weight and height are being dealt with, but intangible, confusing and immeasurable psychic phenomena and propaganda, what will be the result on the lay mind that cannot either escape from it or incorporate it all usefully as applied to the individual child?"

I am firmly convinced that in the future there will have to be a greater exhibition on the part of mothers, of the most uncommon thing in the world, namely, common sense.

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During the first two years of the war (England), deaths from tuberculosis increased in Glasgow about forty-one per cent. The 1941 record shows no improvement. Overwork, strain, and ill-spent leisure are thought to be responsible for the rise.—S. Laidlaw, M.D., and D. MacFarlane, M.D., *British Medical Journal*.

RETROBULBAR NEURITIS*

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There is probably no problem confronting the oculist upon which there are so many strongly advocated opinions, each definitely at variance with the other, as that of retrobulbar neuritis. On the one hand, an entirely artificial classification of toxic amblyopia has crept into the literature, while on the other, the problem has been reduced, in at least the majority of the cases, to the assumption that retrobulbar neuritis and multiple sclerosis are synonymous. And since we know nothing of the etiology or much that is definite by way of therapy for multiple sclerosis, then it must follow that we know nothing of the etiology or treatment of retrobulbar neuritis. One is not easily convinced that this is the case.

It must be remembered that except for field changes we have nothing objective to assist in diagnosis. The very occasional fundus changes described are probably the exception rather than the rule. It is noteworthy that Paton¹ and Klar² each thought edema of the disc sufficiently significant to report it. If then the one important finding is the change in fields, it would seem logical to use perimetry as a basis for classification of the retrobulbar neuritides. The question of chronicity does not impress one as of nearly the importance some writers give it.

In retrobulbar neuritis, complete blindness may develop slowly or quite rapidly with a dilated or fixed pupil as in total transverse neuritis, or there may be a very limited interruption of conduction involving only the macular fibers, as in axial retrobulbar neuritis. These entities, so far apart clinically, are quite as widely separated in etiology, prognosis, and therapy. Whether one or both eyes are involved does not seem of great importance. Surely all of us have seen typical "tobacco amblyopias" involving one eye a considerable time before the other. One case, a man of thirty-eight, suffered recurrent attacks of retrobulbar neuritis of the right eye every time the left antrum became infected. He was relieved promptly each time the antrum cleared under irrigation. Why one nerve should be more susceptible to a given toxin than its fellow is not easy to understand. But that definite toxins do have a greater affinity for some nerve or nerves than for others is not a situation peculiar to retrobulbar neuritis. Consider the ulnar nerve in plumbism.

Retrobulbar neuritides seem to fall logically into

* Presented before a recent meeting of the Kansas City Society of Ophthalmology and Otolaryngology.

three great groups. The first of these is that in which the retrobulbar neuritis is just another symptom of a complex neuropathological entity. The field changes are not too consistent, but the related symptoms lead us to natural conclusions of diagnosis and prognosis. And for each member of the group the treatment of the retrobulbar neuritis is that of the disease. True, in some instances, the best we can do at present is to give the disease a name. But then there are some other branches of medicine, as well as ophthalmology, that occasionally run into similar difficulties.

Leber's Disease which occurs particularly in males with a hereditary tendency, at about the twentieth year of life, with a rapid loss of visual acuity, one eye being involved usually a few weeks before the other, belongs in this first group. There are usually slight degrees of papillitis followed later by secondary atrophy. Some improvement in vision may occur but the disease lacks the general propensity of retrobulbar neuritis to spontaneous recovery.

The typical scotoma is a central one often breaking through to the periphery, most often up and in. According to Groenouw³ this type of central scotoma occurs in seventy-five per cent of the cases, while Bell⁴ places the incidence at eighty-eight per cent. In about one-third of the cases there is a peripheral contraction. Ronne⁵ felt that the central scotoma with its sector break-through indicated a subchiasmal defect in the nerve trunk. According to Hancock,⁶ when recovery does occur, it may first be seen centrally, so that a ring shaped scotoma may develop.

The pathology is based apparently upon a single case, that of Rebsteiner.⁷ This case showed an overgrowth of glial cells with an atrophy of the nerve in the papillo-macular bundle. Intraocularly there was nerve fiber layer and ganglion cell atrophy.

The etiology is unknown. Various theories such as its origin from some mysterious toxin, temporary pituitary disease, abiotrophy, have been advanced. None has been universally accepted, and none can be conclusively refuted. But it will be noticed that in this condition there are several characteristics that lead one to feel that he is dealing with a specific neurological entity; that the retrobulbar neuritis is part and parcel of a specific nervous disease. The fundus changes, the hereditary tendency, the age incidence, and the exceptionally associated evidence of organic nervous disease (such as epilepsy, tremors, insanity, et cetera) all lead one to feel that Leber's disease properly belongs in our first group of retrobulbar neuritides.

Specific infections: Of these tuberculosis, either by direct extension from neighboring structures or by metastasis, rarely may be a cause. Syphilis more commonly causes nerve damage. The pathology and

treatment is that of the specific infection. In the case of syphilis, suffice it to say that the field and ocular manifestations are about as varied as the manifestations of lues in the rest of the body. The diagnostic methods available to us are too well known to bear reutterance.

Herpes zoster ophthalmicus is rarely complicated by a type of retrobulbar neuritis. This is associated with a total loss of vision and optic atrophy.

Plumbism, with its peripheral neuritis, lead line in the gums, wrist drop, headache, and colic, may produce eye symptoms. Lead may cause an homonymous hemianopsia which one would be inclined to consider as part of a saturnine encephalopathy, rather than a true retrobulbar neuritis. Retinal hemorrhages, retinitis, and vascular changes occur. These may take the forms of spasms, arteritis, or periarteritis. Some of these are undoubtedly secondary to a lead induced nephritis. But a true retrobulbar neuritis does occur marked by bilateral pericentral scotomata with no peripheral field defects.

Pathologically, the nerve lesion has been shown to be an inflammatory one in the sheath, with thickening of the sheath and vascular changes. In the case of lead, both primary neuronotoxic and secondary vascular mischief play their part in the ocular damage.

The treatment is that of lead poisoning.

Iodoform and iodine may produce field defects, usually pericentral scotomata, which tend toward favorable recovery when the drug is removed. Peripheral constriction has been added especially in cases where Pregle's Solution was used intravenously for septic conditions.

The fundus may show narrowing of the vessels and brownish discoloration.

Other specific toxins that may produce retrobulbar neuritis as part of a general picture of toxic damage have been mentioned in the literature. Of these thallium, used in some facial creams, has produced bilateral central scotomata and cataracts. Inorganic arsenic, thyroid, apiol, and even sulfanilamide (Bucy,⁸ 1937) have produced neuritis.

Organic nervous disorders associated with demyelination constitute a group of conditions that may have retrobulbar neuritis associated as one of the symptoms.

Schilder's⁹ Disease, a disease of early childhood, in which there is massive subcortical demyelination of the cerebrum and cerebellum followed by gliosis, may have blindness added to the deafness, spastic paralysis, apathy, and eventually death which mark its course.

Devic's¹⁰ Neuro-Myelitis, another disease in which demyelination is a prominent factor, may have neuritis of the optic nerve associated. Here we find

changes in the lower cervical and upper dorsal cord. And though the optic neuritis may precede the myelitis, yet the paresis, loss of reflexes, and trophic disturbances are quite as striking.

Disseminated Sclerosis and Acute Disseminated Encephalo-Myelitis, diseases again of demyelination, are likewise most definitely neurological entities of which the retrobulbar neuritis is merely a part. Fortunately in the latter disease papillitis and some hemianopic defect is common, so that we have at least a clue to diagnosis.

In the case of multiple sclerosis we are less fortunate. Optic neuritis is said to be frequently the first symptom of the disease with other symptoms appearing anywhere from six to twenty or more years later. For this reason one can not lightly dismiss the possibility of multiple sclerosis, especially when a unilateral retrobulbar neuritis appears. And this is usually of the type to be discussed presently as the axial retrobulbar type. But the age incidence (usually under forty), unilateral involvement, acute onset, all point to multiple sclerosis as a possibility. And in such cases spinal fluid examination and most careful neurological examination are urgently indicated.

There is too much reliable evidence to show multiple sclerosis as a cause of retrobulbar neuritis without other tangible findings at the time, to lightly dismiss this disease. Uthoff¹¹ and later Gunn¹² placed the disease as responsible for one-half of the cases observed by them. Scheerer¹³ and Benedict¹⁴ felt that their records substantiated this incidence. But one finds it more difficult to follow the extreme view taken by Adie¹⁵ that "with rare exceptions the only cause" for acute retrobulbar neuritis is disseminated sclerosis. Walter Lillie¹⁶ seems to be more and more inclined toward this extreme position, although admitting other causes as a possibility. Lillie recommends foreign protein therapy and pilocarpine sweats, but feels that "in most cases vision returns to normal with out treatment."

Undoubtedly, retrobulbar neuritis is commonly a symptom of multiple sclerosis just as it is of the other conditions above mentioned. Likewise, it is often a first and only symptom. But the fact that a person with retrobulbar neuritis, with no clinical or serological evidence of that neurological happy hunting ground, multiple sclerosis, may later, in some instances years later, develop multiple sclerosis, by no means establishes the antecedent retrobulbar neuritis as part and parcel of multiple sclerosis. No more so than a pregnancy in an individual with multiple sclerosis years later, can be considered as part of the disease. At least from the practical point of view it would seem most injudicious to treat as multiple sclerosis every case of retrobulbar neuritis without

any other evidence of that disease. And indeed until we know at least something concrete about the etiology of multiple sclerosis, it would seem sound to make exhaustive studies for possible sources of the neuritis even in the presence of such inconclusive phenomena as lost abdominal reflexes. It has been my misfortune to have seen several patients who were needlessly deprived of useful vision for as long as three years because of the vicious tendency of calling all cases of retrobulbar neuritis without a neon arrow pointing to the etiology, multiple sclerosis.

The whole situation is especially disturbing since there is nothing pathognomonic in the clinical laboratory findings of multiple sclerosis. And the manifestations of the disease are, to say the least, not stereotyped. One sometimes wonders, if all cases of clinically diagnosed multiple sclerosis could be autopsied, how many might fail to show the typical plaques, the only thing pathognomonic of the disease.

A dense and unilateral central scotoma varying in shape and size with occasionally hemianopic or quadrant scotomata, and in general a predilection for the papillomacular bundle, seems to be the commonly accepted field defect.

It is not my intention to add to the confusion already existent concerning sinusitis as a cause of retrobulbar neuritis. Surely every oculist has seen cases clear, as if by magic, when infected sinuses were opened and drained. In one instance of an acute bilateral retrobulbar neuritis, with an associated purulent pansinusitis, it was possible for us to restore vision almost at will within a few hours by packing the middle fossae and sphenopalatine recesses with pledgets soaked in adrenaline. Recovery would last about twelve hours. There would then be a relapse followed by another recovery after the same treatment. This sequence continued until drainage was established from the ethmoid cells when the sight remained good. The instance of the patient relieved by irrigating his contralateral antrum has already been mentioned. Every oculist can recall a considerable number of similar cases. Yet one feels that the sinusitis may merely be a toxic process, even the hyperplastic variety, and not necessarily any complicated mechanism as erosion of bone protecting the nerve which Van der Hoeve,¹⁷ Redslob,¹⁸ Worms,¹⁹ and others have demonstrated to occur at times. Nor is the process necessarily pressure from a distended sphenoid with the subsequent edematous strangulation at the foramen that Crane²⁰ and Letchworth²¹ have been able to demonstrate.

Any brief for sinus disease per se as a cause of retrobulbar neuritis meets two obvious objections: (1) Rarely is retrobulbar neuritis found in sinus disease, which is extremely prevalent. (2) In cases of

retrobulbar neuritis, sinus disease, even allowing much conjecture as to condensing osteitis and x-ray evidence of bone absorption and softening, is not common enough to be convincing.

Sinusitis may be a cause, and when it coexists should be treated. But its causal effect, in the majority of cases, is as a focus of infection just as any other focus may be a cause. It is my belief that most of these are the effect of an infectious focus on a nerve the resistance of which is lowered often by a vitamin B₁ deficiency.

Van der Hoeve's²² sign of symmetrical enlargement of the blind spot with retention for a time of central vision, is not conclusive as a diagnostic criterion, but it may be helpful at times in sinus infections.

The second group of cases is that in which peripheral field contraction is the outstanding finding.

Ergot, a drug acting directly on smooth muscle, may be the cause of a transient amblyopia, but atrophy of the nerve does not occur. The other symptoms of ergot poisoning, such as pains in the limbs, paraesthesias, gangrene, and uterine contractions, may be associated.

In this condition the principal field defect is a peripheral contraction to which a central scotoma is only sometimes added.

The ophthalmoscope shows retinal vasoconstriction and edema. Experimentally Peters²³ found the vessel walls and ganglion cells of the retina degenerated.

The anilin group, which includes coal tar hair dyes (Keschener,²⁴ Rosen), trinitrotoluol, and amidobenzol, may produce, as well as occasional hemorrhages and a violet discoloration of the retina, a retrobulbar neuritis with peripheral field constriction to which may be added a central scotoma.

The ophthalmoscope reveals constricted arteries, tortuous veins, a hazy disc, occasionally hemorrhages, and sometimes a violet discoloration of the retina.

These chemicals which may enter the body through the skin or by inhalation of fumes or dust seem to be eliminated when workers are removed from contact, and all the symptoms disappear. Consequently there is little that has been done by way of pathological study.

Felix sand (aspidium) which has been used as an anthelmintic, is similar to, but much more severe than quinine in its ocular manifestations. Symptoms usually come on within twelve days of administration, and the amaurosis may be complete and permanent or temporary. There is a constriction of the peripheral field. An interesting feature in forty-seven cases reported by Stulp²⁵ was that seventeen were unilateral.

The fundus usually shows constriction of the retinal vessels and edema. Optic atrophy may follow.

Experimentally, degeneration and chromatolysis of the ganglion cells and inner nuclear layer cells, as well as optic nerve degenerative changes have been produced.

Quinine and its derivatives (quinidine, chinolin, optochin, eucuprin) produce visual symptoms much more frequently than the general practitioner realizes. And it may do this even in relatively small doses. Duggan and Nanavati²⁶ report a case after one gram, Elliot²⁷ after 0.13 grams. Schwabe²⁸ after 1.25 grams. There may follow a complete amaurosis with a permanent atrophy, but much more commonly there is a constriction of the peripheral fields, constriction of the retinal vessels, and a limited optic atrophy. While the tendency is toward recovery, there is usually some permanent visual defect. Tinnitus and deafness are apt to precede the visual symptoms.

Not only is there constriction of the retinal vessels in this disease, but there may be, according to Smith,²⁹ edema added so that the picture of obstruction of the central artery (cherry red spot and all) may be produced. The field constriction in these cases is greatest for blue.

A very considerable amount of experimental work has revealed chromatolysis and degeneration of the ganglion cells, some degeneration of the nerve fibers, and later thickening of the walls with still later obliteration and thrombosis of the lumen of the blood vessels.

Quinine probably acts directly upon the nerve elements, but the vasoconstriction is a matter of the greatest importance. Giannini³⁰ demonstrated this beautifully by showing that in dogs (in whom constricted arteries, pale discs, blindness, and ganglion cell degeneration is easily produced by quinine) when acetyl choline was combined with the quinine, neither clinical nor pathological ill effects were observed to follow.

The salicylate group (salicylates, antipyrine, antifebrin, et cetera) produces effects very similar to quinine-tinnitus, deafness, dilated pupils, constriction of the arteries. However, in this instance recovery is usually rapid and complete.

Organic arsenic compounds, especially the pentavalent compounds, may be very toxic. Few oculists have not at one time or another seen a case in which the fields were rapidly constricted after trypanamide therapy. Yet this is one of the least toxic of these compounds, which apparently are most toxic when an amino or substitute amino group occupies the para-position (Young and Lovenhart³¹). Here again we find a constriction of the field and of the retinal vessels. The pathology is that of degeneration in the retina and nerve.

Because arsenicals are so widely used perhaps a

word about them would not be amiss. While Tissot-Daquette³² reported a sudden, complete, and hopeless amaurosis, the usual picture is a rather rapid concentric contraction of the fields occurring somewhere along the course of treatment. This usually happens weeks or months after treatment has been started. The most critical time is about the tenth injection, and the visual symptoms usually precede the headache, ataxia, dizziness, labyrinthine, and other symptoms of intoxication. One must be especially cautious in treating persons over forty and those with any degree of kidney, liver, or arterial disease. And at all times a most careful check on the peripheral fields must be maintained. It is our custom at the Smith Clinic to have the fields checked before starting treatment and after the first, fifth, eighth, tenth, thirteenth, and then every five more treatments. It is amazing to see how rapidly and suddenly the fields can start contracting. There is often some central visual depression associated with the field contractions; therefore, the visual acuity should be recorded before each injection. It takes practically no effort to record visual acuity, and peripheral fields are not too laborious a task. Certainly not when one considers the grief the patient may be spared. It is interesting that the pupillary reaction may be retained even in severe cases and that continued deterioration of the vision may occur over a period of a couple of years ending in atrophy and blindness (Veil³³). Veil has reported improvement after the immediate injection of acetylcholine, and certainly this should be tried. I have seen very definite improvement both in vision and in fields after malaria therapy. In one man the fields, which had dropped about fifteen per cent, and whose vision had dropped to 20/40 in either eye with correction, were returned to normal and his vision improved to 20/15 in either eye after malarial therapy. Another patient, a woman of thirty-eight years, whose fields dropped rapidly after the tenth injection to within twenty degrees of the point of fixation, showed a most remarkable constriction of the retinal vessels which persisted for about ten days even under a variety of vasodilators given by mouth, vein, and as hot baths. In these cases the tryparsamide should be stopped at once and acetylcholine given immediately. Then vasodilation should be maintained by the use of sodium nitrite and hot baths. If the fields continue to constrict one should consider the advisability of malaria therapy. It is important not to lose time in these patients. Field defects will often continue to drop at an alarming rate unless the most energetic treatment is instituted. And if later, one starts arsenic therapy again, it would seem judicious to use the utmost caution checking fields and acuity incessantly. Unfortunately, try-

parsamide is of the greatest service in luetic conditions in which the patient's judgment is notoriously poor, such as paresis. It is, therefore, often difficult to convince such patients of the necessity of having their fields repeatedly checked. The internist and the neurologist are easier to convince, since they can usually remember some concrete example of why fields should be checked.

There is an arsenic kerato-conjunctivitis, sometimes necrotic, associated with iritis, retinal hemorrhage, and even papillitis that has been reported by numerous writers.

The concentric field contraction and the prominent part played by vasoconstriction in this entire group of cases must be obvious. The logical treatment would seem, therefore, to be the vasodilators. Of these acetyl choline and sodium nitrite are very satisfactory, but amyl nitrite and other choline derivatives may prove valuable. Lately nicotinic acid intravenously has given encouraging results. Paracentesis is a procedure that might be tried in extreme cases. We have used it occasionally with doubtful benefit. Lumbar puncture has been used in quinine amblyopia with some success by Alt³⁴ and might be worth considering. Improvement has been noticed after fever therapy, and a hot tub is something that is usually available. This, however, is not nearly as beneficial as malaria treatment. But a considerable amount of benefit can be accomplished by the hot tub provided the temperature is raised high enough and kept up long enough. Probably each of these procedures acts by virtue of its power to produce vasodilation.

Indeed Duggan³⁵ feels that every acute retrobulbar neuritis is due to tissue anoxemia and the result of arteriolar spasm and increased capillary dilation and permeability. Hence, the treatment is always vasodilation. Moon³⁶ states that "many phenomena called toxic are essentially anoxic." Duggan recommends the use of intravenous sodium nitrite thus getting a high blood concentration for a short time, and using a drug whose vasodilator action is relatively prolonged. He feels that vasodilation eliminates the tissue anoxia by bringing oxygen rich blood to the tissues.

The last of our three groups is made up of those cases in which a centrocaecal scotoma is the outstanding change. This group of cases stands in sharp distinction to those exhibiting peripheral field contraction, and has been attributed to numerous toxic substances; tobacco, ethyl alcohol, carbon disulphide, inorganic arsenic, optochin, et cetera. These cases may also arise in the absence of any discoverable toxic substance, endogenous or exogenous. If one checks the central fields in all cases where careful refraction fails to give satisfactory results, he becomes amazed at how often a mild so called toxic amblyopia

may exist. Some of the cases to follow will illustrate this point.

Peripheral neuritis may coexist.

Let us consider some of the more common toxic agents briefly.

Tobacco is said to give centrocaecal scotomata for red and green before form with the peripheral field intact. The older conception was that most heavy smokers are heavy drinkers and therefore alcohol also plays a part. There are many startling discrepancies of either tobacco or alcohol as a cause, *per se*, of toxic amblyopia.

1. The amount of tobacco necessary to produce toxic symptoms varies tremendously. In one of our patients the amount was so small that not only was he a total abstainer but did not even like persons who did indulge. This variance in the amount necessary to produce toxic symptoms has been explained as "varying susceptibility," a phrase meaning nothing.

2. Most authors agree that these patients are generally below par at the time they first show symptoms.

3. Most of these individuals smoke or drink for years and are symptom free until such time as their general health is poor.

4. Even after complete abstinence there may be a considerable time before improvement starts.

5. Once cured, recurrences are uncommon, even when the patient goes back to his smoking and drinking. Gunn,³⁷ Usher and Elderton³⁸ thought drinking might actually be beneficial.

The pathology is a degenerative change in the fibers involved and a degeneration in the ganglion cells.

Ethyl alcohol: These cases are said to occur in persons with long established drinking habits. Yet de Schweinitz³⁹ kept a monkey continuously and gloriously drunk for six months with no ophthalmoscopic or pathological eye changes. This substance is about identical with tobacco in its eye effects. It has the same objections as a cause *per se*.

Methyl alcohol: This is similar except that the onset is sudden, blindness is often complete, and recovery may be very limited. In those cases that do show retrogression, the same type of scotoma is seen. Of course there may be the general symptoms of stupor, prostration, abdominal pain, convulsions, and death with methyl alcohol poisoning.

In cases of slow absorption, as by inhalation, along with the headache, obscure nervous and gastrointestinal symptoms, there may be a more gradual deterioration of vision with field changes similar to those of tobacco or ethyl alcohol.

Here the pathology is a widespread degeneration of the ganglion cells and nerve fibers even as far as the geniculate bodies.

While wood alcohol is quite like ethyl alcohol, it differs in that it is poorly eliminated and thus has a much more cumulative effect. This effect may be due to the formation of formic acid in the blood. It has been demonstrated that the oxidative processes of the retina are greatly reduced. Some observers believe that light increases the damage to the retina in these cases.

Carbon disulphide: This substance is used largely in the rubber industry. It causes a type of retrobulbar neuritis quite similar to that of alcohol. Hearing is often affected. Headache is common. It takes months of absorption to produce symptoms, and these are usually preceded by a period of euphoria. If the patient is removed early enough from contact, vision usually returns fairly promptly. If contact is continued or is renewed, partial atrophy is likely.

It is in this group of cases that thiamine chloride seems to play a really remarkable role. One gains the impression that two conditions are necessary for this type of retrobulbar neuritis to develop. First, there must be a toxic substance of the type that has a predilection for the tapetodmacular bundle, and second, there must be a sufficiently susceptible nerve for the substance to act upon. Apparently thiamine chloride can increase tremendously the power of resistance of these cases. Conversely it has the beneficial effect leading to recovery when it is used as a therapeutic agent. There has been a great deal in the literature of late months on the value of this vitamin in retrobulbar neuritis. I shall not attempt to quote from the many authors that have broached the subject. But it appears that this particular group of cases is the one most benefited. One feels that some of the adverse criticisms of B₁ as a therapeutic agent have arisen from the use of it in cases in which vasodilators were the proper drugs. Of course one should hunt for and remove any toxic substance or focus that might be discoverable. However, in many of these cases no such substance is traceable.

Experimental evidence has been advanced to show that in B₁ avitaminosis there is a reduction in oxygen consumption. There is now common acceptance of the idea that a large fat intake spares B₁, and that a large carbohydrate intake wastes it. Therefore, the larger the proportion of caloric intake is fat, the smaller the amount of B₁ that is required by the body. B₁ is needed for the oxidation of carbohydrates, but not for the oxidation of fats. This assumes special significance if we accept the ability of brain tissue especially cerebral cortex, to oxidize only carbohydrates (Quastel,⁴⁰ J. H.). Briem⁴¹ found that thiamine increases the action of acetyl choline. Excessive doses of the substance merely lead to its destruction in the body. There have been some untoward effects of excessive doses demonstrated in animals

experimentally. Probably no similar conditions could arise in man.

Since there has been considerable evidence to demonstrate that lack of B₁ may be responsible for optic neuritis, (Cronin,⁴² 1933; Carroll,⁴³ 1936, and a host of others), it certainly is worth a trial.

In this particular group of cases it is indispensable in our armamentarium of therapy. At least in my cases the results have persuaded me. To demonstrate let us briefly review a few instances from many similar cases.

CASE REPORTS

Case No. 1 Male. Age fifty-one. Railroad section foreman. A heavy smoker and a total abstainer from alcohol. Complains that his left eye failed him three years ago. Some months after this his right eye failed until he was obliged to quite his job. He says that his general health was below par, but he had not lost any great amount of weight lately or in the last three years.

Examination revealed normal fundi and vision of 15/400 in the right and 20/400 in the left eye with no improvement by any correction or with the pin point. Careful general examination failed to reveal any focus of infection. Blood chemistry and serology were found to be normal.

Fields showed the typical scotomata for red and green larger than for form in the centrocaecal area.

He was told to quit smoking, and was given a diet rich in B₁, thiamine by mouth, and by vein. He was hesitant about quitting his smoking because he had tried that for several months with no result. However, he soon showed improvement. Within two weeks the vision in his right eye was 20/300 and in the left 20/200. The centrocaecal scotomata gradually decreased in size until six months later his blind spots were perfectly normal for form and color, and his vision in either eye, with a small correction, was 20/15.

This man had been told that there was nothing to do for him because the condition that he suffered from gets better by itself. This advice cost him nearly three years of useful work. He is now back at work, looks fine, and has gained considerably in weight. His vision which was defective for red and green for a while is now normal. He says he "never felt better in his life." He has been checked again recently and is still in excellent condition.

Case No. 2 Male. Age seventy-five. White. Farmer. Complained that he has had his glasses changed frequently but none of them seemed to do any good. His vision had been especially bad for one year.

Examination revealed vision of 20/60 in either eye, unimprovable. Otherwise his eyes were normal except for considerable sclerosis of the fundus vessels and a few drusen. Fields showed the typical scotomata for red and green greater than for form in the centrocaecal area. General examination revealed no foci of infection and his serology and blood chemistry were normal.

He was given a diet rich in B₁, and this vitamin was given to him by mouth and by vein. In two and a half months his vision with correction was 20/20 in either eye. The patient volunteered the information that his hearing had improved too. His blind spots were normal. He looked and felt much improved.

Case No. 3 Male. White. Age twenty-six. Itinerant worker.

Had been drinking for two days. Suddenly went blind

a few hours before first seen. His vision was reduced to shadows and he reeked of poor liquor.

This patient was hospitalized and treated as though he had taken wood alcohol which he suspected he had done. He was lavaged. He was sweated with blankets and light cradle, given epsom salts, and intravenously B₁ at two hourly intervals.

The next morning he was able to distinguish faces and that night to read the paper. When discharged, two days after admission, his vision was 20/20 in either eye. His peripheral fields, like each of the above cases was normal. He had a slight centrocaecal defect for red in either eye. He was asked to return later for follow up which he failed to do.

Case No. 4 Male. White. Age twenty-three. Filling station attendant. Stated that his vision had been poor for eight years. He had had his glasses changed repeatedly but none of them seemed to help.

Examination revealed only a small central scotoma for red and green but not for form, and a bulging of the blind spot toward the point of fixation for a few degrees for form.

He was treated like the others with the result that his vision, which was 20/40 in the right eye and 20/70 in the left, in the course of three months improved to 20/20 in each eye.

The patient was then refracted and found to take no correction.

These are merely a few of numerous similar cases. Many of them showed some focus of infection which was removed where this was feasible. Others showed little or nothing abnormal. Probably there is no individual in whom we could not find some focus of infection if we looked long and hard enough. However, it does not seem reasonable to remove gall bladders and sundry and divers parts on the slightest provocation. But when such foci are relatively easily removable, they should be removed. The patient should be put on a high B₁ intake. The tremendous doses we have at times used are open to the criticism that we are wasting the vitamin. On the other hand we are sure that the patient is getting an ample supply. One thing that should always be done is to carefully check the blood sugar and if this is high, have it regulated. We have not routinely put our patients on a carbohydrate poor diet, but have cautioned them to limit their sweets. In this way one makes sure that as much as possible of the B₁ is available for the nerve tissue.

SUMMARY AND CONCLUSIONS

Retrobulbar neuritides fall logically into three groups.

First; those that are part and parcel of some systemic disease of which the retrobulbar neuritis is merely a symptom. The diagnosis, prognosis, and treatment is that of the disease.

Second; those cases in which peripheral contraction of the fields is the outstanding finding. These usually show some constriction of the vessels of the fundus. Much that is called toxemia in these in-

stances is anoxemia of the retina. These are benefited most by the use of vasodilators.

Third; are those cases in which centrocaecal scotomata are the outstanding findings. Thiamine chloride should be given and proper precautions should be taken to see that as much of the vitamin as possible is made available for the nervous tissue.

Since toxicity may play a part in every type of retrobulbar neuritis, every effort should be made to discover and remove any toxic focus or contact.

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What is the age at which a person may expect, according to averages, to live just as long again? At age thirty-five the expectation of life is itself thirty-five years, so that a white person at age thirty-five may expect, according to averages, to live to age seventy, which happens to be the oft-quoted biblical "three score years and ten." No doubt it is this figure that Dante had in mind in the opening lines of his Divine Comedy, where he refers to himself as being halfway on the road of life. Writing this, supposedly in 1300, he was then thirty-five years old.

This halfway station, when a man's expectation of life is equal to his age, is somewhat variable according to changes in mortality, but much less so than the average length of life. According to mortality in the United States, the former figure has varied only from about thirty-three to the present thirty-five—that is, by two years—in the last four decades, during which the average length of life has increased by almost fifteen years.—Statistical Bulletin, Metropolitan Life Insurance Company.

PEPTIC ULCER

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I have felt for years that our treatment of peptic ulcer is unsatisfactory. The morbidity of the disease is high; recurrence is frequent; the treatment is lackadaisical, inadequate, and in that it is entirely symptomatic and palliative, it is unscientific.

Originally in my treatment of the disease I followed the standard text book pattern, known as Sippy treatment. I was a faithful disciple. I put my patient to bed, fed him milk and cream alternate hours with Sippy powders No. 1 or No. 2 as indicated. But I found that after two or three weeks my patients were worse, some of them pitifully worse, depressed mentally and physically. I tried the recommended variations of the treatment but finally came to the conclusion that the entire prevailing conception of the disease was wrong, that there must be a re-examination of the disease both as to its etiology and treatment.

Etiologically, one can discuss ulcer from two different origins: (1) that it is strictly a local lesion and (2) that it is a manifestation of a constitutional disease of which the ulcer and hyperacidity are secondary and relatively unimportant symptoms. Much experimental and clinical evidence supports the theory of the central causation of the disease; chiefly the frequency of ulcers following cerebral lesions and vagal and sympathetic disturbances. To me the clinical evidence is convincing that not only are duodenal and gastric ulcers local manifestations of central nervous disease but I am also including in the syndrome a number of gastro-intestinal symptoms that have been masking under other aliases, such as colitis, nervous colitis, spastic colitis, post cholecystectomy distress and that other unnamed illness that has for its habitat the left side of the abdomen. The elder practitioners called all this "nervous dyspepsia." This may be poison to the modern laboratory diagnostician, but I refer it to you again as probably as satisfactory a name as we have for the disease.

I feel that this entire syndrome, including the ulcer and the hyperacidity is a disease of stress and maladjustment, a tension disease. I make one exception to which I will refer later.

Among railroaders, with whom I am chiefly concerned, the high incidence of the disease is easily explained. During the last ten years, with the depression and the consequent reorganization of the roads, the lots of the men have been far from easy. Reduction of forces, overwork, economies have

caused stress and strains that have sifted down through the ranks even to the Mexican on the section. Especially trying have been the lots of the minor executives, the head clerks, the chief clerks, the straw bosses, who have had to carry heavy loads under that intolerable condition, responsibility without authority. There are maladjustments on the jobs; square pegs in round holes, men doing desk work who should be switching, men doing supervisory work for which they are temperamentally unfitted and visa versa, men doing routine work who are potential executives. Among my cases in this group was one man in charge of a roomful of typists. Two or three of these females knew exactly how to get this poor fellow's goat. To cure his ulcer he had to take a demotion and go back to routine work.

The average routine in handling these cases is about as follows: the patient tells the doctor he has "stomach trouble", in fact he may be a repeater and tell the doctor he has an ulcer. Gas, belching, sour stomach, relieved by food and soda. Pain, food, comfort. Pain, food, comfort. That is the sequential triad. A gastro intestinal x-ray is ordered. If the roentgenologist reports a filling defect in the stomach or duodenum the doctor says, "Yes, you have an ulcer. I will put you on Sippy treatment. Here is your diet and a prescription for Sippy powders."

If no filling defect is reported back the doctor is stumped but the patient probably gets the same dietary advice. A negative x-ray report is of little significance. Because the roentgenologist uncovers no filling defect in the duodenum or stomach is not proof that one is not present at the time of the examination; neither is it proof that an ulcer was not present last week or will not be present next week. Ulcers are like pimples; they come and go.

One word before I go on about diets and alkalies. Of two things I am firmly convinced; first, the ordinary restricted diet usually prescribed for these patients is wrong and, second, that alkalies are unnecessary and contraindicated. Consider for a minute the usual diet ordered for these ulcer patients. I mention the milk and cream regime only to condemn it. You will remember it was taught not so long ago that milk was a proper and sufficient food for the first two years of an infant's life. Now ask any pediatrician what he thinks about this. Not that milk is not helpful to some of these patients in a reasonable subsidiary role. Meat is either forbidden or restricted to white meat of chicken or baked fish. Proteins are definitely indicated in the treatment of ulcer. A slice of roast beef or broiled steak will take care of the hyperacidity better than any alkali. Of course these patients cannot get away with corn on the cob or greasy pork chops or fried potatoes. Pan-

cakes are generally taboo on these diets but the only thing wrong with a well baked pancake is the excessive amount of syrup in which it generally floats. I give my patients a generous well balanced diet, taking care that there is variety, plenty of vitamins and enough calories for the job on hand. A glass of milk or a sandwich will take care of the mid-morning or mid-afternoon hunger, and the same at bedtime if there be nocturnal distress. These men may have their dietary idiosyncrasies which one must respect, providing they are genuine. But many of their aversions are either bad habit or the result of faulty dietary advice.

The end result of these low-calory, restricted, monotonous diets and the persistent use of alkalies are too often protein deficiency, avitaminosis, a mineral shortage, or an alkalosis, either frankly clinical or sub-clinical.

After my preliminary history, examination, physical and x-ray, has confirmed my suspicion that I am dealing with this syndrome, the most important part of the examination is yet to come. When I have time and the assurance that I will not be interrupted I take these patients to my office to talk things over. I ask him to tell me his story; let him talk about anything that comes into his head, just asking enough questions to keep the narrative within bounds. I get his back-ground, both personal and familial. I get his reaction to his job, to his superiors on the job and to things in general. I never neglect to go into his family life. Are there domestic problems? Debts? Difficulties in balancing the budget? Does he start to work in the morning with a song in his heart or with his ears pinned back by the vehemence of a nagging wife? Are there troublesome children? Hope deferred which maketh the heart sick? Forgotten psychic insult only to be uncovered by psychoanalysis? All these are just a few of the factors that go into the etiology of nervous dyspepsia.

This takes several interviews and all the time I am guiding the inquisition to episodes which I suspect to be the psychological quirk which is the ultimate cause of the dyspepsia. I find it better not to take immediate notes. These men are often skittish and gun-shy until they get their stories off their chests and some trifle may stop the flow of their confessions.

In most of these cases the general practitioner will have no trouble uncovering the conflict at the root of the disease. In some cases, however, an expert psychiatrist may be necessary.

TREATMENT

And now what to do for your patient. Medically sedation is necessary. I generally use bromides. To

this I add belladonna or hyoscine in full therapeutic doses. However, recently there has been put on the market a tablet of phenobarbital, atropine and hyoscine that is quite efficient and more convenient than the liquid prescription. As mentioned before, the diet must be ample and varied. Malnutrition, avitaminosis, protein and mineral deficiency must be guarded against and in most cases these elements must be replenished. But more important you must get the patient re-oriented psychologically. Explain to him frankly the cause of his ulcer or dyspepsia. Be simple; do not bore him with burdensome detail or your verbosity.

By this time you should have sized him up and sensed the best approach. Some you must weep with; some you must pray with; some you must cuss; and to some, all that is necessary, is a simple statement of the problem. Theirs is an emotional problem. You must stimulate a healthful emotion to replace his perverse reaction. For instance, one of my patients had recurring ulcers for years. My interviews convinced me that he had been the victim of a dominating mother-in-law—wife combination. The father-in-law had been a preacher and the old lady had run not only her family but the church and everything else including the daughter's family affairs. It was a difficult situation and I could not see the answer and began to hedge. Finally I said "I feel that it is rather late to do much with your case. It has become chronic but if twenty-five years ago you had gone home drunk some night and thrown both your wife and her mother out of the house you would not have your ulcer." He stared at me for some time, leaned back in his chair, let go a fine belly laugh. The next day he asked for his release, and said he was going back to Texas to sit at the head of his own table for a change. That was four years ago. I have not seen him since but he writes me that his ulcer is cured.

Concerning the patients with the vague shifting complaints generally referred to the lower abdomen; the fellow with what is generally referred to as "colitis". From their capricious appetites and faulty dieting, many of them are in a state of chronic malnutrition. A rest in bed is often beneficial. Their pain is real, often a neuritis from avitaminosis. Analgesics may be necessary but generally a hot water bottle or an electric pad will suffice. If constipation is obvious and urgent—and most of them are constipated, a small oil enema is indicated. But re-education and psychic treatment is your only hope. A talk on the physiology of digestion and the functions of the colon and the evils of cathartic habit is helpful. A daily bowel movement is not necessary. Many perfectly healthy people do not have more than two or three bowel movements per

week. The colon is not an eliminative organ but an absorptive organ by which the body avails itself of necessary fluids, vitamins and minerals. These folks are martyrs to vicious dietary habits. Often a doctor starts them on their way, later made worse by advice from friends or culled from advertisements or health columns of the daily papers. These cases will call for all the ingenuity and perseverance and personality that you possess. You are dealing with near-psychopaths. But the results will justify your patience and perspicacity.

The above sketchily outlined treatment will take care of from eighty to ninety per cent of the cases. And now I come to the exception which I noted above. Assuming that you have given your patient a careful physical examination: that you have ruled out certain surgical conditions such as appendicitis, cholecystitis, malignancy, some kidney conditions, that you have considered some endocrine disturbances, climacteric episodes in both male and female, hypoglycemia both frank and subclinical, both hypo- and hyperthyroidism, allergy and so forth, there are ten to twenty per cent that I put in a class by themselves. I refer to the intractable cases, the chronic dyspeptics, those unfortunate butts of jokes and jibes and Rabelasian humor. The literature back through Shakespear to the Roman Horace and the Greek Aristophanes have bitter quips at these unfortunates. Unfortunates they truly are, below-par males and females. They have not what it takes. They are congenetically poor protoplasm. They have headaches, malaise, dyspepsia, dysmenorrhea. On their abdomens you find the scars of their operations; appendectomies, cholecystectomies, cholecystotomies, herniotomies, oophorectomies, salpyngectomies, nephrectomies and I have actually seen on one belly the scars of three operations for adhesions. Truly these bellies, I have read some place—are the happy hunting ground of the occasional operator. The experienced surgeon shuns them like the plague. Operations, diets, alkalies, lavage gastric colonic adsorbents and absorbents, all to no avail. I can spot them coming and I confess I try to shunt them off on the more naive confrere.

One must depend on the roentgenologist to inform one of the presence or absence of a filling defect in the duodenum or the stomach or any gross organic deformity of the gastro-intestinal tract. I must know if there is a filling defect in the stomach. If gastric ulcer does not heal promptly—I would say if there are not positive signs of healing in three to five weeks by roentgenologic examination and complete healing in two to three months, one must consider the possibility or even probability of carcinoma. Gastric carcinoma is like brain tumor;

(Continued on Page 262)

President's Page

To the Members of The Kansas Medical Society:

Twenty-three physicians of The Kansas Medical Society, as well as several members of the Auxiliary, were registered at the recent American Medical Association Convention in Atlantic City. In spite of, or perhaps because of, the war situation, this has been one of the largest American Medical Association meetings ever held.

The House of Delegates functioned efficiently and well, and I believe that all important decisions made would be thoroughly in accord with the wishes of Kansas medicine. In later editions of the President's Page, I wish to discuss further several of these actions such as the approval of the National Physicians' Committee, and the action taken to prevent the inclusion of medical services in hospitalization and insurance plans. However, in the rest of this page I wish to bring to the attention of the Kansas profession the urgency of the medical needs for the armed forces and the necessity of meeting this need at once.

There are 180,000 physicians in the United States. Of these, 160,000 are active. Of this 160,000, 22,000 are already commissioned in the armed forces as of June 1, 1942, and 20,000 more are needed before January 1, 1943. One-half of this number is needed in active service by August 1, 1942. 160,000 voluntary enrollment forms have been returned by the doctors of this country. Of this number, 137,000 have been completely processed in Washington. All of the enrollment forms have been processed on physicians thirty-seven years of age or below, and all of the forms on the members between thirty-seven and forty-five years of age will have been completely processed within another three weeks. The Procurement and Assignment Service in Washington expects to call in person every able-bodied available physician below thirty-seven years of age to immediate service by July 15, and within a few weeks after this the physicians between thirty-seven and forty-five years of age will receive a similar call.

No one could hear the discussion of this question by Mr. McNutt, Surgeon General McGee, Dr. Lahey, and Colonel Seeley and other leaders without realizing that immediate service is required of this group of physicians. It is also authoritatively stated that General Hershey, head of Selective Service, has ruled that the question of dependency will not be recognized in any person rating a commission of first-lieutenancy or higher, and therefore, dependency will not be considered as applying to medical men.

The inescapable conclusion is that the need for medical men under forty-five years of age is immediate and urgent and must be immediately met.

Sincerely yours,

Henry N. Tichen, M. D.

President, The Kansas Medical Society.

EDITORIAL

MILITARY NEEDS FOR PHYSICIANS

The military forces of the country have urgent and immediate need for the services of a large number of doctors of medicine. The contemplated size of the Army, the addition of the Air force as a sizeable new unit, the development of a two ocean Navy, the methods and conditions of modern warfare, and numerous other factors have contributed greatly to that result. The military agencies of the nation and the Procurement and Assignment Service in Washington have, therefore, requested that every physician under forty-six years of age should apply for commission in the medical corps without delay.

To assist physicians in obtaining commissions, Army medical officer recruiting boards have been established in each state. These boards have been given authority to provide and approve physical examinations, to prepare necessary application papers, to grant commissions, and to assist in all other ways in filling the vacancies which now exist in the Army medical corps. The Kansas Medical Officers Recruiting Board, which is composed of Major R. W. VanDeventer and Major H. J. Dixon, opened offices at 215-17 Federal Building, in Topeka on May 19, and has engaged since that time in the above activities.

The Procurement and Assignment Service, through its national and state committees, is attempting to the fullest extent possible, to assist in coinciding the needed number of physicians for the military forces with civilian, industrial, and medical educational needs. It must be remembered in this connection, though, that the needs of the military agencies will require a very high percentage of all physicians under forty-six years of age and that, therefore, classifications of unavailability can be given only in very unusual instances. Physicians under forty-six years of age who are classified as unavailable will in the main be those who are the only physicians in their communities or who are otherwise irreplaceable for civil, industrial or medical educational work.

The medical officers recruiting boards have been authorized to grant commissions in the rank of First Lieutenant to physicians of less than thirty-six years and ten months of age, and commissions in the rank of Captain to physicians between that age and forty-six years. Commissions of higher rank may be given only in instances of certain definitely prescribed qualifications.

The Navy has substantially filled its quota in the higher age brackets but it does have urgent need for a considerable number of younger physicians. The Army has need for many thousands of physicians in all age groups up to forty-six years.

As is announced elsewhere in this issue, physicians throughout the country who are less than forty-six years of age will soon receive letters from the Procurement and Assignment Service in Washington requesting that they apply for commissions if they have not already done so. Selective Service regulations will then become operative to the place that physicians who have not applied for commissions and who are classified as available and physically fit will in all probability need to be given a Selective Service re-classification of 1A. This is true by reason that National Selective Service Headquarters has ruled that individuals who are offered commissions and who refuse to accept them may not retain their Selective Service order numbers or a classification of 3A based upon dependents.

The medical profession will undoubtedly be glad to know that all arrangements and plans for the Procurement and Assignment program are now complete and that every doctor of medicine now knows what he can do and what it is desired for him to do. The medical profession has always been the first to volunteer its services to the nation in the time of war. It will not fail to do so in the present emergency.

SOCIETY COMMITTEES

Dr. Henry N. Tihen, President, has announced in this issue of the Journal on page 263, the new committee appointments for the year 1942-43.

Committee work has always been one of the most important functions of the Society program. To the committees are referred for consideration most of the projects and activities in which the organization engages, and through them are accomplished a great portion of the Society's efforts.

The Society at present has twenty-two standing committees and five special committees. The committees are divided on a specialized basis and an attempt is made to appoint members thereon who are interested and well familiarized with the work in their respective fields. Special committees serve on that basis until their work has been proven to be needed over a period of years, whereupon they are designated in the Constitution and By-Laws as standing committees.

Dr. Tihen has appointed three new special committees to serve during the next year. These are as follows: a Committee on Control of Appendicitis;

a Committee on Conservation of Hearing and a Committee on Plasma.

The name of the Committee on Medical Preparedness has also been changed this year to the Committee on War Work.

Dr. Tihen is to be congratulated for the excellent distribution and the arrangement of his committee appointments. The 341 members appointed on the Society committees for 1942-43 include at least one appointment for every county medical society in the State and in fact include at least one appointment for almost every county in the State. Likewise, the appointments indicate that careful consideration was given to efficient and equitable geographical distribution on each of the individual committees.

The committees will undoubtedly be confronted with many problems in attempting to carry forward their work during the next year. It is essential, though, for the sake of the war effort and for conditions after the war that this be accomplished. Likewise, the excellent appointments which Dr. Tihen has provided will be of great assistance toward that end.

ROBERT B. STEWART

Dr. Robert B. Stewart, who has been a most valuable member of the Editorial Board since its inception about seven years ago has located, at least temporarily, in California. He carries with him the best wishes of the Editor and his deepest gratitude for an immense amount of work done for the Journal, especially on the editorial page. It will remain our hope that he will return to his native State and resume his former position in medical and community life.

Dr. L. R. Pyle and Dr. Don C. Wakeman are serving with the armed forces and will be joined shortly by Dr. L. E. Eckles, reducing the Board to one member who will endeavor to carry on.

WAR PRODUCTION

During the recent state meeting at Wichita, the editor had the unusual privilege of making a tour of the Boeing Airplane plant, which is an important link in our country's war effort. The courtesy was extended by Mr. J. Earl Schaefer, the Vice-President of Boeing and Manager of the Wichita plant, who personally conducted the small party. Being average physicians, engaged in repair work rather than in mass production by assembly line methods, we could not help being greatly impressed by the magnitude of the enterprise.

Not the least interesting department is that de-

voted to the testing of metals by high-powered photographs, which show the structure as a microscope reveals the cellular arrangement of a tumor. X-rays reveal flaws in castings and another method deposits an iron stain in any flaw. However, the most interesting thing is the human phase with hordes of workers from our middle western states, busily engaged in individual tasks that contribute to the production of airplanes for our armed forces.

The visit gave a spiritual uplift and a new confidence, with the vision of the mighty coordinated effort going on all over the nation, which will lead to an ultimate victory for democratic ideals.

CANCER CONTROL

CARCINOMA OF THE STOMACH

James S. Hibbard, M.D.

Wichita, Kansas

In a paper appearing in this section of the Journal of The Kansas Medical Society, Dr. Howard Snyder of Winfield has very ably discussed the general subject of carcinoma of the stomach. He brought out the facts concerning gastric carcinoma in relation to the impressions and thoughts of the patient. He described in detail the enormous effort being expended by the Women's Field Army, The Kansas Medical Society and the Kansas State Board of Health in educational campaigns so that the public will not only be well informed of cancer of the stomach, but will seek competent medical attention at the beginning of the early signs and symptoms of the disease.

The present problem, of vital importance, concerns entirely the attitude of the practicing physician toward carcinoma of the stomach. The unfavorable results in the treatment of this disease, occurring even after the patient seeks medical attention, present a challenge which should not be ignored. In the light of our present knowledge, fifty per cent of patients with cancer of the stomach are clinically inoperable at the time of diagnosis. When patients of this group are explored, only forty to forty-five per cent are deemed resectable. The immediate mortality of the cases in which resection is done varies from ten to twenty-five per cent. Follow up studies reveal that only twenty-five per cent of the cases surviving gastric resection can be expected to live

five years. These statistics agree favorably with those reported by Cooper¹ from the New York Hospital. In a total of 264 cases with proved cancer of the stomach he found only ten cases living and free from the disease three years later. He stresses the fact that few physicians practicing in small communities are fortunate enough to observe cured cases and that physicians seeing large series of cases in our medical centers only occasionally see five year cures.

Analysis of facts show that the medical profession as well as the patient may be at fault for the late diagnosis of carcinoma of the stomach. Far too frequently patients showing symptoms of indigestion are not thoroughly investigated. The knowledge that there are no typical symptoms of early carcinoma of the stomach should definitely be accepted. Failure to recognize this fact and failure to demand an accurate diagnosis of all cases presenting symptoms of indigestion definitely increases the percentage of advanced cases.

Gray² points out that the familiar picture of gastric carcinoma painted in text books and impressed on the minds of many physicians is that of an advanced stage and if a cure is to be attained, the disease must be recognized before the characteristic signs develop.

Another factor responsible for a delay in diagnosing cancer of the stomach is the widespread disagreement on the malignant possibilities of gastric ulcer. Not only do physicians practicing in small communities allow carcinoma to progress in an area previously diagnosed as a benign ulcer, but also reports of such cases are not infrequently found in our large clinics and hospitals. Either these patients had failed to report for follow up studies at the appointed time or an error had occurred in the x-ray interpretation.

The common impression in the medical profession is that the x-ray diagnosis is extremely accurate in differentiating gastric lesions. Comfort and Butsch³ report a seven per cent error in diagnosing malignant gastric ulcers in contrast to a thirty per cent error in diagnosing benign gastric ulcers. Gray states that at the Mayo Clinic roentgenologists diagnose about nine per cent of the malignant ulcers of the stomach as being benign, whereas in a much higher percentage it is impossible to draw a definite distinction between a benign and a malignant ulcer. Therefore, the general impression should be that the roentgenologist is about eighty-five to ninety per cent accurate in the diagnosis of cancer of the stomach.

The apparent widespread information that a study of the gastric contents for achlorhydria is extremely important should be discouraged. Even though achlorhydria at times suggests the possibility of a

diagnosis of carcinoma, the presence of free hydrochloria should never be interpreted as conclusive proof of a benign lesion.

The treatment of choice when it is possible to differentiate between a benign and a malignant ulcer is exceedingly difficult to determine. The accepted answer advocated by many of the leaders in this field is the use of a short medical test period, checked up by accurate x-ray observations. It is pointed out that favorable response to this medical test period is a criterion of benignancy. Relief of symptoms, disappearance of the ulcer crater in the roentgenogram, and disappearance of blood from the stools is said to be indicative of a benign ulcer. In the Wichita hospitals we have been very much disappointed in using a routine medical treatment period. Far too many patients have developed inoperable carcinoma of the stomach even after they have fulfilled all the requirements of a benign lesion. The incidence of these cases is not great, but their importance is shown by the many case reports appearing in the literature from all hospitals and clinics. A great responsibility is assumed by any physician who recommends non-surgical treatment in a patient presenting a doubtful ulcerating lesion of the stomach.

A crusade against the above mentioned factors appears to be the main point of attack in reducing the entirely too high death rate in carcinoma of the stomach. Proper educational programs should be instituted in order to impress on the medical profession the changing aspects of gastric carcinoma. Our slogan should be first that indigestion in adults demands an accurate diagnosis, and second, that all chronic gastric ulcers are potentially malignant and should be treated accordingly.

During the last few years it has been our custom in Wichita to advise all cases of chronic gastric ulcer to be hospitalized in preparation for surgery. We feel that the low mortality rate of gastric resection is more acceptable than the incurrent dangers of malignancy.

ASEPTIC RESECTION

Although aseptic intestinal resection was described thirty-four years ago, it has only been within the last four years that a decided effort has been made to lower the mortality in gastric resection by its use. Probably this is one of the most important refinements to be developed in surgery of the stomach. In the early days many questions arose as to the relative merits of various types of procedures, methods of sutures, and principles of reestablishing gastrointestinal continuity. The results of these refinements appear to depend largely upon the individual traits of the operator and although deserving meticulous study, they should not be considered as the

basic principles of gastro-intestinal surgery.

Aseptic resection was primarily developed to use in carcinoma, due to the achlorhydria present. Because of the enthusiasm of the originators, however, many surgeons are using it routinely for the entire gastro-intestinal tract. Wagensteen^{4,5} has demonstrated that its superiority, in contrast with the open anastomosis, is so great that its followers are gradually increasing in number.

Aseptic anastomosis may be accomplished either by the clamp method or by the Parker-Kerr⁶ basting stitch method. The more commonly used clamp method as first advocated by Wangenstein and later by Holman⁷ depends upon the principle of cautery asepsis and hemostasis. Two rows of aseptically placed sutures are placed both anteriorly and posteriorly to special thin bladed clamps. As the clamps are withdrawn, the inner layer of sutures is drawn taut and tied. Both writers advocate a continuous suture of fine catgut for the inner row and an interrupted fine silk suture for the outer row. This method shows a well-healed line of mucosa in fourteen days, as demonstrated by Wangenstein and Gerbode.⁸ When compared with the open method, in Gerbode's experiments, it is found superior. Furthermore, the Furniss clamp and its modifications, as well as the sewing machine clamp, are mentioned only to be condemned. The use of these mechanical clamps necessitates perforating the bowel lumen, which obviously destroys the asepsis of the closed method.

In our cases of aseptic resection we have observed a much smoother convalescence, although the time consumed at operation is definitely lengthened. We have been impressed with the fact that soiling is impossible and have noticed that the post operative return of fluid from the stomach by suction is much less bloody than in the open anastomosis. No difficulty has been encountered as yet when the patients were allowed food by mouth.

The basic principles of cancer surgery should be strictly adhered to in the removal of carcinoma of the stomach. Procedures of less magnitude, irregardless of the size of the lesion, should not be tolerated. Segmental resection and Billroth I type of resection in general definitely do not meet the requirements of wide excision and should be relegated to benign lesions. Preliminary gastroenterostomy allows a resectible malignancy to advance to an inoperable state. Gastroenterostomy in non-resectible cases does not materially lengthen the life of the patient and its humanitarian value is questionable. In lesions of the cardia the surgeon should not be tempted to demonstrate his ability by performing useless gastrotomies, although he should not forget that these lesions in selected cases have now been justly con-

signed to the realm of radical resection.

The value of the technique of including the entire lesser curvature and the omentum in an attempt to include the lymphatic areas as widely as possible, has been definitely proven.

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Treatment of Physicians Testifying in Court for Government: The occasional attempts of lawyers, by insulting, abusive attacks, to impeach the scientific objectivity, credibility and truthfulness of physicians testifying in court on behalf of government agencies, such as recently occurred in a Federal Trade Commission hearing, are assailed by *The Journal of the American Medical Association* for August 30. Commenting on "Doctors in Court and Lawyer Tactics," *The Journal* says:

"Frequently physicians are requested to testify in court in behalf of governmental agencies. As public spirited citizens they do this at great sacrifice of time and energy and with no remuneration other than reimbursement for expenses. In cities such as Washington, Chicago and New York, where the Post Office Department, the Food and Drug Administration and the Federal Trade Commission are particularly active, the demands made on the time of such physicians are sometimes inordinately heavy. Government officials have said repeatedly that the enforcement of the laws administered by the agencies mentioned would hardly be possible without this generous, voluntary cooperation of the medical profession. When a physician appears in court in the performance of a civic duty he is usually treated with courtesy and respect. Most practitioners of law recognize the nature of the situation and the professional status of their colleagues in medicine. Some lawyers, however, in their zeal to win, forget the decencies. In a recent hearing before the Federal Trade Commission a number of distinguished medical scientists, Drs. A. J. Carlson, Victor C. Myers and Donald D. Van Slyke, testified for the government against claims made by the Bristol-Myers Company for its product 'Sal Hepatica.' The claims concerned largely the problem of acidosis. According to an account of the trial, these scientists, who were there to perform a public service, were subjected to an insulting, abusive attack, endeavoring to impeach their scientific objectivity, credibility and truthfulness, and they were assailed then as to their motives and integrity. Apparently the attorneys were not content with an examination of the facts of the testimony. In this instance, it seems likely, the tactics employed will reap their just reward."

In every mental institution tuberculosis is a problem of first order. Of the deaths from tuberculosis in the United States, 5.2 per cent occur in mental hospitals while only 15.9 per cent are in tuberculosis hospitals.—*American Review of Tuberculosis*.

MEDICAL SCHOOL

POLYURIA AND BRAIN TUMOR*

L. E. Maurer, M.D.

Frank C. Neff, M.D.

Kansas City, Missouri

The advisability of follow-up observation, in a child whose only complaint and evidence of abnormality at first was polyuria, is illustrated in the case we hereby report.

CASE REPORT

First Hospital Admission, October 29, 1940. This twelve year old boy was admitted to the University of Kansas Hospitals with a diagnosis of diabetes insipidus. Four months prior the patient had a sudden onset of nocturia and polydipsia. Urine was passed as many as eight times nightly. The family physician prescribed pituitrin and later pitressin with some temporary relief, but at this time the patient's out put was about 3500 cc. daily. Physical examina-

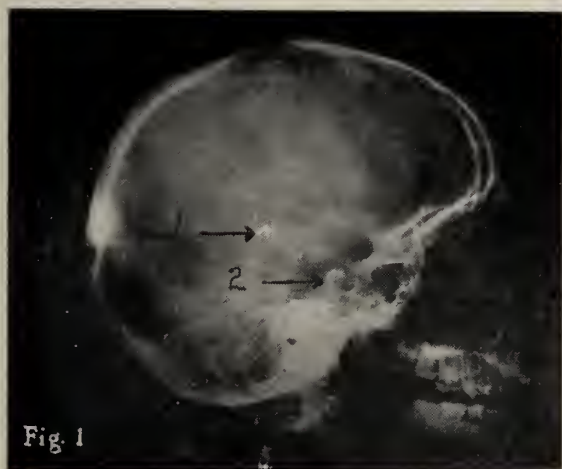


Fig. 1. Roentgenogram of Skull. 1. Calcified pineal body (without significance). 2. Normal sella tursica.

tion was entirely negative. X-ray revealed a pineal body markedly calcified, without significance, and a small sella. A normal blood pressure was found throughout the course. During the hospital stay the patient was given surgical pituitrin, one-half cc. intranasally twice daily, and become symptomatically improved.

Eight months later he developed visual loss, headaches and vomiting. The patient had stopped the use of pituitrin intranasally, followed by increased polyuria. He was having progressive loss of vision until he was unable to read. The mental attitude had undergone a marked change. For a period he became impatient and provoked at the family, but then went to the other extreme of satisfaction with everything.

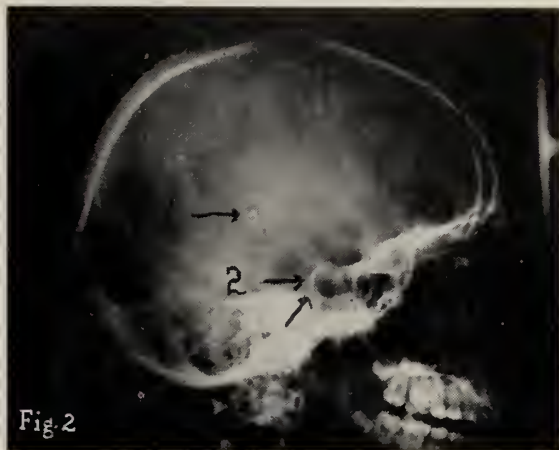


Fig. 2. Nine months later. 1. Calcified pineal body. 2. Roentgen film shows that there had been an increase of 100 per cent in size of sella, and there had developed an irregularity of the posterior clinoid plate.

Second Admission, August 4, 1941: The boy was cheerful and cooperative. The gait was hesitant, suggesting blindness. The eyes reacted to light but questionably to accommodation. There was no vision in the right eye, but 15/200 in the left eye. The fundi showed bilateral cupping with some whiteness of both discs, indicating optic atrophy. Blood pressure was normal. Blood counts and chemistry normal. Roentgen examination of the skull gave no definite evidence of increased intracranial pressure. Reference made to plates taken nine months before showed approximately 100 per cent increase in size of sella, consistent with an intrasellar tumor.

Third Admission, August 18, 1941: Craniotomy was performed by Dr. Teachenor and Dr. Coburn. The right optic nerve was found to be swollen and displaced mesially. Bulging between the two optic nerves was a tumor mass, purplish-red in color. The growth was found to have a tough capsule which was free of the optic chiasm. A portion of the tumor as removed with biopsy forceps. The histologic section showed undifferentiated teratoma of the sella. Following the operation there was a stormy time for three or four days but gradual and steady improvement with dismissal on the eighteenth post-operative day in good condition. There was some improve-

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ment in the condition of the right eye; the left eye showed considerable improvement. The patient was able to color books and performed actions previously impossible.

Fourth Admission, October 11, 1941: The boy had gotten along very well for one week after going home until he acquired an upper respiratory infection, after which he lost his appetite and began vomiting. He became unable to retain fluid or food. The polyuria and polydipsia again became quite marked. Physical examination revealed pallor and emaciation. There was no detectable vision in the right eye, but some in the nasal field of the left eye. Death occurred on the second hospital day.

Autopsy presented a malignant chordoma, arising from the bony tissue at the base of the sella tursica causing pressure atrophy of the pituitary gland; additional findings were internal hydrocephalus, encephalomalacia of right frontal lobe, bronchopneumonia and Meckel's diverticulum.

SUMMARY

The significant features of this case are: Sudden onset of polyuria with negative x-ray and physical examination; symptomatic improvement with the use of pituitrin; the development of radiographic and clinical signs of an intra-sellar tumor nine months later; an immediate transitory improvement following removal of the tumor; the finding at biopsy and autopsy of malignant chordoma of sella tursica. Pneumonia was the immediate cause of death.

Nursing Council Conducting Survey—One of the first projects of the Nursing Council on National Defense, organized in July 1940, was a nationwide survey of registered nurses to determine their availability as the need arose, Pearl McIver points out in the March-April issue of *War Medicine*, published by the American Medical Association, Chicago, in cooperation with the National Research Council, Washington, D. C.

The Japanese death rate is 17.4 per 1000 as compared to ten or eleven in the United States. Japan's present death rate, in fact, resembles ours of 1900. Individual causes of death in Japan are about as prevalent now as in this country about 1900. For example, the United States tuberculosis death rate now is forty-five per 100,000. In Japan in 1937 the rate was 204, closely resembling our tuberculosis death rate in 1900 of 196. The picture is similar for diarrhea and enteritis. America has more than twice as many men to draw on in the military age group as Japan—twenty-five million men from twenty to thirty-four, as against Japan's eleven million in this age group. *Science News-Letter*.

TUBERCULOSIS CONTROL

PROMIN IN THE TREATMENT OF TUBERCULOSIS

In 1938, sulphanilamide was reported to have an inhibitory effect on the development of experimental tuberculosis in guinea pigs but subsequent papers held out scant hope that this agent would prove to be a specific remedy for tuberculosis in human beings.

Promin in its solid form varies from white to light yellow and is slightly hygroscopic. It is highly soluble in water and forty per cent solutions are stable indefinitely and may be sterilized by heat. It is slightly bitter but small amounts may be mixed with the food of animals without impairing their appetite or digestion. Guinea pigs tolerate one per cent promin in their foods and will consume from 300 to 400 mg. of the drug per twenty-four hours. Increasing the concentration of promin to two per cent, causes anorexia which interferes with the quantity of food taken.

In the first experiment, promin to the amount of one per cent was added to the feed of thirty guinea pigs while twenty others received the same diet but without promin. Two days after the feeding experiment began, all guinea pigs (fifty) were inoculated subcutaneously with human tubercle bacilli of known strain. On the eighty-fourth day all the animals in the control group had died and twenty-four of the animals which had received promin were living. Promin was then removed from the diet of twelve of the survivors. After eighty-two days more, thirteen animals still lived, five of which had received promin for the entire period (166 days) and the other eight for the first period of eighty-four days only. The purpose of this procedure was to determine if latent tuberculosis would become reactivated when treatment was discontinued.

The value of a chemotherapeutic agent must be appraised not only on survival time, but also on the character of the disease process. With one exception the degree of tuberculous involvement in the animals that received promin was notably less than in the controls.

Although the results indicated that in many of the animals promin either had prevented the establishment of lesions or had caused their eventual disappearance, another effect of the drug which is perhaps of more importance was that which it exerted on the cellular elements of the lesions. In the vast majority of the animals in the treated group

that had lesions, the histopathological characteristics of the disease process apparently were modified favorably. This was especially true of the lesions in the parenchymal tissues. The lesions were usually small and discrete and the epithelioid phase of the reactive process predominated. Necrosis was infrequent and a tendency of the process toward fibrosis was observed frequently. These features of the morbid process were in marked contrast to those that characterized the disease in the control group of animals. In the latter the disease was extensive, destructive and progressive.

The objectives of the second experiment were: (1) to confirm results of the first and (2) to determine what effect, if any, promin might have on a tuberculous infection introduced at the same time as or at varying periods before treatment with promin was begun.

Eighty guinea pigs were selected and divided into eight groups. Group one consisted of twelve animals infected but not treated (controls). Group eight consisted of twenty animals whose treatment began two days prior to infection. Groups two to seven each contained eight animals and treatment was begun, in relation to the day of infection, at various intervals as follows:

- Group 2—day of infection
- Group 3—three days after
- Group 4—one week after
- Group 5—two weeks after
- Group 6—four weeks after
- Group 7—six weeks after

All animals (one exception) reacted to tuberculin. Generally speaking, the reactions of the animals that received promin were less severe than those of the untreated animals.

While the general physical condition of the animals remained satisfactory, changes indicative of toxic manifestations were noted in the blood and spleen. Studies, as yet incomplete, indicate that in guinea pigs, promin may induce a hemolytic type of anemia but with adequate regeneration as indicated by a corresponding reticulocytosis.

The difference in survival times of the several groups was striking. When the last of the untreated animals died, 189 days after inoculation, eighty-four per cent of the treated animals were still living. Of the treated animals that died, none had sufficient tuberculosis to account for death, and this percentage of deaths might reasonably be considered an average or normal mortality rate for guinea pigs.

Examination of the tissues and organs of the animals showed that all untreated animals were tuberculous, that in fifty-seven per cent of the treated animals no evidence of infection in the visceral organs was found, that in the remainder of

those treated tuberculosis was found (with a few exceptions) of minimal severity and that forty-three per cent of the treated animals failed to show evidence of disseminated tuberculosis.

The failure to demonstrate lesions of tuberculosis in a considerable number of the animals that were treated and the further fact that the disease in the treated animals was, with few exceptions, minimal and nonprogressive indicate that the action of the drug was significant. That fairly comparable results occurred in the treated animals, regardless of whether the administration of the drug was started before or as long as four or six weeks after inoculation with tubercle bacilli, was surprising and must indicate that the drug was effectively operative against a tuberculous infection in which morbid changes already were established when administration of the drug was started.

The conclusion of the two experiments is that promin had a deterrent effect on experimental tuberculous infection. — From *Promin in Experimental Tuberculosis*, Wm. H. Feldman, M.D., H. Corwin Hinshaw, M.D., and Harold E. Moses, M.D., *Amer. Rev. of Tuber.*, March, 1942.

Note: Encouraged by these carefully controlled animal experiments, promin has been used guardedly in the treatment of a few cases of tuberculosis in human beings. Administration of the drug has proved difficult since its toxic effect in man is found to be much higher than in the guinea pig. In certain cases it has been found necessary to discontinue treatment because of unfavorable symptoms attributed to the drug itself. In other case where treatment has been prolonged (five months or more) results thus far show varying effects. In a few, definitely demonstrable improvement occurs; in others little or no change is observed; while in some patients, the disease goes on developing progressively with no apparent effect from the treatment.

It is obvious that a freshly infected guinea pig presents a very different pathological picture from that of a well developed human case with destruction of tissue and extensive fibrosis which interferes with the access of the drug to living tubercle bacilli.

Despite the present lack of convincing evidence of promin's value in the treatment of human tuberculosis, there appears to be a definite feeling that further trial in skilled hands is indicated.

PEPTIC ULCER

(Continued from Page 253)

at times the diagnosis is easy, self evident, it just cannot be anything else. And at other times it is very difficult. There may be just the mildest dyspepsia and slight ill health; even it may be entirely symptomless until obstruction and attendant vomiting tell the story.

Any gross deformity of the duodenum or of the stomach calls for surgery. At times apparent obstructions relax under the regime mentioned above. I have also seen gall bladders relax and resume their functions under the same treatment. I am not qualified to discuss exact surgical procedures to be employed, except to say that I do not think that a properly done gastro-enterostomy is the discredited operation that one might suspect from the literature

coming out of some of the clinics. By the same token I am not prepared to recommend a gastric resection for a stubborn duodenal ulcer.

A mortality of two to six per cent is reported from some clinics. But these are the results of work done by surgeons with special training. The ideal gastric resection includes the entire acid-bearing area of the stomach, the premise being, "No acid, no ulcer" but the end results of these gastric resections are still in doubt both as to immediate and collateral implications. So I say, "Let the master surgeons, especially skilled in this line of surgery, go ahead with the pioneer work and the rest of us can wait until the returns come in from the hinterlands before adding gastric resections to the exploits of even our best general surgery."

SUMMARY

The consideration of duodenal and gastric ulcers as an entity should be discontinued because they are symptoms of a more inclusive syndrome of digestive complaints which are neuro-psychic in origin. Hence, their treatment with restricted diet and alkalies is unsound.

The family doctor is generally psychiatrist enough to handle these cases; occasionally a trained psychiatrist should be called in.

A certain number of these cases are intractable. In the present state of our knowledge of heredity and of the sympathetic nervous system no treatment is of avail.

The underlying principle of the modern management of cancer is coordinated team work. It is improbable that any one man can perform all of the duties and carry out all the techniques required. Any organization that sets itself up to manage cancer must contain at least a surgeon, a roentgenologist and a pathologist. This is the minimum requirement in personnel. There should also be added to the group an internist to advise concerning the diagnosis of cancer in deeper organs, and specialists who devote attention to each particular part of the body for advice in connection with tumors in special locations. It would be well also to have on such a team a chemist and a physiologist. These could offer many helpful suggestions concerning special features of this disease. Each member of the team should have equal standing. Each should be considered as a consultant who is able to add something to the full understanding of cancer and to its management in any particular patient.—James P. Simonds, M.D., Chicago, Ill., *Med. Jour.*, Vol. 81, No. 5, May, 1942.

About one-fourth of the families in the United States have good diets; more than a third, diets that might be considered fair; another third or more, diets that are poor.—Bulletin, National Tuberculosis Association.

NEWS NOTES

PROCUREMENT AND ASSIGNMENT

The Kansas Committee on Procurement and Assignment for physicians forwarded the following bulletin to each member of the Society on June 29:

"IMPORTANT INFORMATION RELATING TO THE PROCUREMENT AND ASSIGNMENT SERVICE PROGRAM FOR PHYSICIANS"

To: All Members of The Kansas Medical Society—Information was given at the recent meeting of the American Medical Association held in Atlantic City, New Jersey, which is of particular importance in regard to the needs for physicians in the military forces and as to certain new procedures which are being placed in effect immediately to assist in filling those needs.

The Kansas Committee on Procurement and Assignment Service for Physicians discussed this information at a meeting held on June 21 and decided that a bulletin describing this data should be prepared and forwarded to the entire membership of the Society.

The following, therefore, is an attempt on our part to summarize the above information and also certain other information on this topic:

I. Need for Physicians: The Army has urgent and immediate need for a very large number of physicians up to forty-six years of age; the Army Air Force has similar need for a large number of physicians in the same age group; and the Navy needs approximately 3000 physicians who are less than fifty-seven years of age.

The needs in this connection are very serious and they must be supplied without delay.

The Government, therefore, issued a request at the Atlantic City meeting that every doctor of medicine in the country who is less than forty-six years of age should immediately apply for a commission.

The above request is an urgent one. The Government asks that every obtainable physician under forty-six years of age realize that his services are needed; that they are needed now; and that he can render great assistance to his country by applying at the present time.

II. Changes in the Procurement and Assignment Program: To facilitate the filling of these needs, the Procurement and Assignment Service program has been materially changed, effective June 15. The new program will operate as follows:

All physicians under forty-six years of age, who have not as yet applied for a commission, will receive a letter from the Procurement and Assignment Service in Washington within the near future, requesting that they do so.

Every physician receiving a letter of this kind will then be given two weeks in which to apply for a commission.

If a physician thereupon applies for a commission and is found to be unavailable by reason of civilian, industrial or medical educational necessities, or is physically disqualified for military service, he will be expected, at least for the present, to serve his country in a civilian capacity. Physicians in this category will also be exempted from the provisions of the Selective Service Act.

If, however, a physician does not apply for a commission within the two week period, his name will be forwarded

to State Selective Service Headquarters with notice that he is no longer under Procurement and Assignment Service jurisdiction and with authorization for his Selective Service status to be re-classified. This procedure would probably mean that the physician involved will immediately be placed in class 1-A, inasmuch as National Selective Service Headquarters has ruled that an individual can not maintain a 3-A classification or retain his Selective Service order number if he is offered a commission and refuses to accept it.

The re-classification to 1-A would, also, obviously mean that the physician would soon be inducted under the Selective Service Act, regardless of his dependents or other circumstances, and that he might or might not be transferred to the Medical Corps at a later date.

III. Classifications of Availability and Unavailability: The present needs are so great that it will be difficult for the State Procurement and Assignment Committees to classify any sizable number of physicians under forty-six years of age as unavailable. Physicians within this age group who are classified as unavailable will in the main be those who are the only sources of medical service in their communities or who otherwise are irreplaceable for civilian, industrial and medical educational needs. The present theory in this regard is, and must be, that older physicians will need to take over the work being performed by young physicians, in order that the latter may be made available for military service.

IV. Physicians in the Older Age Groups: Where physicians in the older age groups feel they can be spared from their present work, they will render a very valuable service to their country by volunteering to fill vacancies in civilian and industrial practice. Physicians who can assist in this matter are asked to file their names with the Society Central Office or this Committee.

V. Places to Apply for a Commission: Every state now has a Medical Officer Recruiting Board which is authorized to provide and approve physical examinations, to complete application papers and to otherwise expedite the obtaining of Army Medical Corps commissions for physicians. The Kansas Board for this purpose is located at 215-217 Federal Building in Topeka. Kansas physicians desiring to apply for Army commissions should write that Board for an interview appointment. Applications for other branches of the service may be made through the Surgeon Generals of those services.

VI. Physical Requirements: The physical requirements in the Navy are very strict. Color blindness, deficient vision and other types of disabilities will disqualify an applicant.

The Army has two types of physical requirements, one for regular service and another for limited service. Regular service requirements are rather strict. Limited service requirements, however, are very liberal and make possible the acceptance of applicants with various kinds of disabilities. The only difference between regular service and limited service is that the latter does not permit duty with combat troops.

By reason of the above difference in physical requirements, rejection by one branch of the service does not necessarily mean that acceptance can not be had in another branch.

Our Committee feels the above information is of very great importance and that it deserves the careful consideration of every doctor of medicine in the country. The foremost and proudest heritage of the medical profession has

always been that it has never failed in the time of an emergency. It must not fail America in the present one.

Kansas Committee on Procurement and Assignment Service for Physicians: F. L. Loveland, M.D., Chairman, Henry N. Tihen, M.D., C. D. Blake, M.D., C. S. Huffman, M.D., N. E. Melencamp, M.D., W. M. Mills, M.D., C. C. Nesselrode, M.D., Alfred O'Donnell, M.D., Marion Trueheart, M.D."

Additional data in regard to the needs for physicians in the military forces is contained on page 255 of this issue.

COMMITTEES

Dr. Henry N. Tihen of Wichita, President, has announced the following new Society committees to serve for the year 1942-1943:

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Marion Trueheart, M.D.....	Sterling

ANNUAL RE-REGISTRATION

The annual registration fee for Kansas doctors of medicine is due and payable on July 1, 1942. The fee is \$1.00 until October 1, after which time there is a penalty of \$5.00 which is required by law for reinstatement of a license.

Notices have been mailed recently to the last known address of each licensee and if any doctor has not received his notice he should immediately notify Dr. J. F. Hassig, Secretary of the Kansas State Board of Medical Registration and Examination at 905 North Seventh Street, Kansas City, Kansas. Payment of the fee, under the Medical Practice Act, cannot be waived for any reason whatsoever. The Board wishes this were possible in the case of physicians serving in the armed forces, but under the law this is impossible.

APPOINTMENTS

Governor Payne H. Ratner recently announced the appointment of Dr. F. L. Loveland of Topeka and Dr. Hugh A. Hope of Hunter as members of the Kansas State Board of Health.

Dr. Loveland and Dr. Hunter take the places of Dr. James T. Reed of Iola and Dr. W. C. Lathrop of Norton, respectively, both of whom died recently.

COMMISSIONS

The Kansas Medical Officer Recruiting Board located at 215 Federal Building, Topeka, has commissioned the following Kansas physicians as officers in the Medical Corps, of the Army, as of June 20:

Ralph E. Bula, Lyons.....	First Lieutenant
Harold R. Barnes, Hutchinson.....	Captain
Donald A. Kendall, Great Bend.....	Captain
Edward D. Greenwood, Topeka.....	Captain
Leo L. Wenke, Great Bend.....	First Lieutenant
Funston J. Eckdall, Emporia.....	Captain
Virgil E. Brown, Sabetha.....	First Lieutenant
Rae Arthur Richeson, Kansas City, Kansas.....	Captain
James T. Fowler, Osawatomie.....	First Lieutenant
Lyle F. Schmaus, Iola.....	Captain
Rudolph T. Unruh, Goessel.....	Captain
George R. Lee, Yates Center.....	Captain
Douglas H. Wood, Pittsburg.....	First Lieutenant
Harold L. Graber, Topeka.....	First Lieutenant
Edward H. Stratemeier, Askew.....	First Lieutenant
Kenneth R. Hunter, Lebo.....	First Lieutenant
John F. Nienstedt, Hartford.....	First Lieutenant
Hiram P. Jones, Lawrence.....	Captain
Edwin W. Enders, Lawrence.....	Captain
James F. Zagaria, Topeka.....	First Lieutenant
Raymond J. Leiker, Great Bend.....	Captain

CIVILIAN DEFENSE

The county medical societies are urged to complete and to strength their plans for civilian medical defense.

In the event of sabotage and other civilian disasters, care-

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THE KANSAS MEDICAL SOCIETY

fully prepared plans of this kind would be of particular value in providing care for the injured.

The Society central office will be happy to provide any information or assistance possible or desired on this subject.

OSTEOPATHIC SANITORIUM

The Southwest Osteopathic Hospital and Sanitorium at Wichita recently announced that it has closed its school of nursing.

The institution formerly held itself out to train registered nurses.

A. M. A. MEETING

The ninety-third annual session of The American Medical Association was held in Atlantic City, New Jersey, from June 8 to June 12. The total registration at the meeting was 8,238. Guests registered from the following countries: Canada, Brazil, Cuba, Columbia, Argentina, Mexico, Chile, Venezuela, Costa Rica, Peru, San Salvador, Haiti, Uruguay, Bolivia, Paraguay, South Africa, Persia, China, Greece and British Guiana.

Kansas members who attended were as follows: Dr. Lewis G. Allen of Kansas City, Dr. C. D. Blake of Hays, Dr. Iran R. Burket of Ashland, Dr. Ralph I. Canuteson of Lawrence, Dr. L. A. Calkins of Kansas City, Dr. Cora E. Dyck of Moundridge, Dr. E. S. Edgerton of Wichita, Dr. H. M. Floersch of Kansas City, Dr. John L. Grove of Newton, Dr. J. F. Hassig of Kansas City, Dr. C. A. Hellwig of Wichita, Dr. Irene Koenke of Halstead, Dr. J. L. Lattimore of Topeka, Dr. Paul H. Lorhan of Kansas City, Dr. F. L. Loveland of Topeka, Dr. L. R. McGill of Hoisington, Dr. H. C. Markham of Parsons, Dr. Don Carlos Peete of Kansas City, Lt. Commander Lucien R. Pyle of Topeka, Dr. Earl Saxe of Topeka, Dr. C. F. Taylor of Norton, Dr. H. N. Tihen of Wichita, Dr. Claude C. Tucker of Wichita, Dr. Wm. S. Walsh of Halstead and Mr. C. G. Munns of Topeka.

Dr. Fred W. Rankin of Lexington, Kentucky, was installed as the new President for the year 1942-43 and Dr. James E. Paullin of Atlanta, Georgia, was elected as President-Elect. Other officers elected were as follows: Dr. William J. Carrington of Atlantic City, New Jersey, as Vice President; Dr. Olin West of Chicago, Illinois, as Secretary; Dr. Herman Kretschmer of Chicago as Treasurer, and Dr. Edward M. Pallette of Los Angeles, California, and Dr. R. L. Sensenich of South Bend, Indiana, as members of the Board of Trustees.

The scientific exhibits and the technical exhibits were among the largest and most complete ever presented.

Decision was made that the 1945 annual session shall be held at New York City. Since the American Medical Association selects places of meeting three years in advance, in accordance with decisions made at past meetings, the 1943 meeting will be held at San Francisco and the 1944 meeting will be held at St. Louis, Missouri.

CONSTITUTION AND BY-LAWS

The Society Committee on Constitution and By-Laws recently completed a new pamphlet containing the Constitution and By-Laws of the Society and the Code of Ethics of the American Medical Society. Copies of the pamphlets were mailed to all members on June 2.

LAMPS ON THE PRAIRIE

A new book entitled "Lamps on the Prairie," describing the history of nursing in Kansas, was recently published under the sponsorship of the Kansas State Nurses Association.

The book was prepared from records, histories and interviews under the writer's program of the Work Project Administration in the State and with the assistance of the members of the Kansas State Nursing Association Committee on the History of Nursing of which Cora A. Miller of Emporia is the chairman.

Copies of the new book may be secured by writing Cora A. Miller, The Kansas State Nurses Association, 817 State Street, Emporia, Kansas. The price of the book is \$3.00.

BLIND PROGRAM

Dr. H. L. Kirkpatrick, Supervising Ophthalmologist, for the Kansas State Board of Social Welfare, recently issued the following report pertaining to examination and treatment services furnished under the Kansas blind program for the month of May, 1942:

AID TO THE BLIND

	May	1942	'38 to '42
New Examinations—Eligible	29	104	2579
Ineligible	20	68	1893
Totals	49	172	4472
Re-Examinations	8	40	466

RESTORATION OF SIGHT

Eligible for Treatment	21	81	1162
Under Treatment			148
Completed			
Still Eligible for "A.B." after Treatment	7	28	229
Ineligible for "A.B." after Treatment	3	34	396
Total	10	62	625

PREVENTION OF BLINDNESS

Eligible for Treatment	12	51	619
Under Treatment			106
Completed Cases			
Eligible for "A.B." after Treatment	1	1	5
Ineligible for "A.B." after Treatment	15	52	391
Totals	16	53	396

BOARD OF HEALTH MEETING

The Kansas State Board of Health held its annual quarterly meeting in Topeka on June 25.

Members of the Board present were: Dr. G. I. Thacher, Dr. G. A. Leslie, Mr. Wm. E. Scott, Dr. J. L. Lattimore, Dr. J. F. Gsell, Dr. H. L. Aldrich, Dr. R. W. Urie, Dr. R. T. Nichols, Dr. F. L. Loveland and Dr. Hugh Hope.

Major actions taken by the Board at the meeting were as follows: Dr. F. C. Beelman, who has been acting Secretary since the resignation of Dr. F. P. Helm in September, 1941, was elected as Secretary and Executive Officer of the Board; Mr. Tom Larsen, who has served as milk inspector, was appointed as Acting Chief of Milk Sanitation to succeed Mr. Leon Bauman who recently resigned to enter medical school; Dr. Fred Mayes, who has been assistant Director of the Division of Child Hygiene, was appointed as Director of that division; Dr. H. R. Ross was appointed as Medical Consultant of the Board; Dr. G. I. Thacher of Waterville was re-elected as President of the Board and Dr. H. L. Aldrich of Caney was re-elected as Vice-President.

Plans were made at the meeting for the use, in this State, of a portable x-ray unit which was offered for loan to the Board by the United States Public Health Service.



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NARCOTIC PERMITS

The attention of all members is called to the fact that Federal narcotic permits must be renewed by June 30.

Renewal of all permits must be made thru application to the office of Collector of Internal Revenue at Wichita, in order to avoid the payment of penalty.

COUNCIL MEETING

A meeting of the Council was held in Wichita on May 14, 1942. Members present were: Dr. Henry Tihen, President, of Wichita; Dr. Herbert Atkins of Pratt; Dr. F. R. Croson of Clay Center; Dr. O. W. Davidson of Kansas City; Dr. Geo. M. Gray of Kansas City; Dr. J. L. Lattimore of Topeka; Dr. Ben H. Mayer of Ellsworth; Dr. Philip Morgan of Emporia; Dr. J. H. A. Peck of St. Francis; Dr. J. W. Randell of Marysville; Dr. G. O. Speirs of Spearville; and Dr. Marion Trueheart of Sterling.

The first order of business was the election to fill present vacancies on the Defense Board. Upon a motion made by Dr. Speirs, seconded and carried, Dr. L. S. Nelson of Salina was elected as a member of the Board and as Chairman thereof for a term of three years. Dr. Tihen explained that another vacancy has existed on the Board for the past two years by reason that the other two members of the Board were authorized to fill the vacancy and that for certain reasons this has not as yet been done. Upon a motion made by Dr. Mayer, seconded and carried, the authorization for the Board to fill the vacancy was continued and the Council requested that same be filled during the next year.

The next item of business pertained to the filling of vacancies on the Editorial Board. Upon a motion by Dr. Davidson, seconded and carried, Dr. W. M. Mills, of Topeka and Dr. L. R. Pyle of Topeka were reelected to three year terms on that Board. Upon a motion by Dr. Trueheart, seconded and carried, Dr. Mills was designated as Chairman of the Board and as Editor of the Journal for a three year term.

Following discussion of whether or not an annual session should be held next year, and if so as to the type of meeting which should be held, upon a motion made by Dr. Atkins, seconded and carried, it was agreed that an annual session should be held in Topeka during 1943. Upon a motion made by Dr. Davidson, seconded and carried, it was also agreed that the number of days of the meeting, the type of program, and the question of whether or not technical exhibits would be invited, should be determined by the Executive Committee of the Society and the Shawnee County Medical Society in accordance with future conditions and developments and as they deem advisable. Dr. Peck stated that he felt the plan used this year of inviting other county medical societies to serve as co-hosts for the annual session had been particularly successful and that he believed this plan should be continued. Dr. Lattimore was authorized to confer with the Shawnee County Medical Society for the purpose of selecting a date or dates for the next annual meeting.

Upon a motion made by Dr. Speirs, seconded and carried, a charter was issued to the Clark County Medical Society.

Adjournment followed.

COUNTY SOCIETIES

The Barber County Medical Society which has not been active for several years was recently reorganized. Officers of the society are as follows: Dr. Walter J. Pettijohn, M.D., of Kiowa as President; and Dr. J. T. Terry of Hardtner as Secretary Treasurer.

The Council has approved the issuance of a charter to the Clark County Medical Society. The officers of the new society are as follows: Dr. I. R. Burket of Ashland as President and Dr. Harold O. Closson of Ashland as Secretary-Treasurer.

The Douglas County Medical Society met in Lawrence on June 2. Dr. Lyle Powell made a report on the recent State meeting of the Society and Dr. H. L. Chambers gave a report on the United States Public Health post graduate course on Venereal Disease which was held at Little Rock, Arkansas, and which he attended.

The Harvey County Medical Society was host to the Tri-County Medical Society on June 1 in Newton. Dr. E. D. McBride of Oklahoma City and Dr. J. W. Kelso of Oklahoma City, were the guest speakers.

The Marshall County Medical Society held a dinner meeting in Marysville on May 21.

The Montgomery County Medical Society held a meeting on May 22 in Independence.

The Mitchell County Medical Society held a picnic on June 18 at Beloit. Speakers were: Dr. F. L. Loveland, Major R. W. VanDeventer and Major H. J. Dixon, all of Topeka, who discussed "Procurement and Assignment of Physicians."

At the May 19 meeting of the Sedgwick County Medical Society held in Wichita the following new officers for 1943 were elected: Dr. H. R. Hodson as President; Dr. J. V. VanVleve as Vice-President; Dr. R. H. Maxwell as Secretary; Dr. Allen Olson as Treasurer; Dr. George Gsell, Dr. J. S. Reifsneider and Dr. Charles Rombold as members of the Board of Directors and Dr. E. H. Terrill as a member of the Board of Censors.

The Southeast Kansas Medical Society held a meeting in Neodesha on June 15. Speakers for the meeting were: Dr. Joseph W. Kelso of Oklahoma City, Oklahoma, and Dr. F. L. Loveland of Topeka. Dr. Kelso spoke on "Cancer of the Cervix" and Dr. Loveland discussed "National Defense and the Medics."

The Wyandotte County Medical Society met in Kansas City on May 19. Dr. J. G. Evans of Kansas City spoke on "Paralysis of Radial Median and Ulnar Nerve" and Dr. F. E. Angle of Kansas City discussed the "Highlights of American College of Physicians Meeting." The Wyandotte County Delegates made reports of the annual meeting of the Society.



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MEMBERS

Dr. D. D. Carr, formerly a director of the Utah State Board of Health of Salt Lake City, was named full time health officer for the city of Topeka, effective June 1.

Dr. E. S. Edgerton of Wichita was one of the winners of golf prizes at the American Medical Golfing Association Tournament which was held on June 8 at the Seaview Country Club, Atlantic City.

Dr. D. T. Gammel formerly of Ulysses is now located in Hugoton. He was also recently appointed as county health officer of Grant County.

Dr. Don Carlos Peete of the University of Kansas School of Medicine was awarded honorable mention for his exhibit at the American Medical Association Meeting held in Atlantic City, New Jersey on June 9-12. Dr. Peete's exhibit was on "Acute Rheumatic Fever and Its Complications."

Dr. Lester Johnson has recently returned to Wichita from Boston, Massachusetts, where he took a post graduate course in otology at the Harvard Medical School.

Dr. C. A. Hellwig and Dr. H. Lester Reed of Wichita are the co-authors of an article entitled "Fatal Anuria Following Sulfadiazene Therapy" which was published in the June 13 issue of the Journal of the American Medical Association.

Dr. H. A. Mercer, formerly of Arkansas City, has moved to Eudora where he is a member of the medical staff of the Sunflower Ordinance Plant.

Dr. C. W. Plowman of Jewell has been appointed health officer for Jewell County to succeed the late Dr. Spencer B. Dykes of Esbon.

Dr. J. W. Yankey, formerly of Mankato, has moved to Esbon where he will practice.

DEATH NOTICES

Dr. Benjamin Bruner, 63 years of age, died May 22 at his home in Wamego, where he had practiced medicine for thirty-nine years. He was born near Onaga on March 3, 1879, and he attended the Kansas City Medical College from which he was graduated in 1903. He was a past President of the Golden Belt Medical Society and a member of the Kansas State Senate in 1916-20. He was also a member of the Pottawatomie County Medical Society.

Dr. Stephen Flatt, 70 years of age, died June 2 at his home in Independence. He was born in Green County, Illinois, in 1872 and was graduated from the St. Louis College of Physicians and Surgeons in 1898. Dr. Flatt was a charter member of the American Congress of Physical Therapy. He was also a member of the Montgomery County Medical Society.

Dr. Raymond William Moore, 69 years of age, died on May 16 at Eureka. He was born at Marshall, Missouri, on September 22, 1872. He attended the University Medical College of Kansas City from which he was graduated in 1901. He practiced first in Arcadia then moved to Eureka where he has been for the past twenty-two years. He was a member of the Butler-Greenwood County Medical Society.

Dr. James T. Reid, 62 years of age, died at his home in Iola on May 14 of cerebral hemorrhage. He was born in Lebo in 1880 and attended the Medico-Churgical College of Kansas City, from which he was graduated in 1901. He was a member of the Kansas State Board of Health at the time of his death. He was, also, a member of the Allen County Medical Society.



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OBSTETRICS—Two Weeks Intensive Course will be offered starting September 21st. Three Weeks Course starting August 10th. Informal Course every week.

OTOLARYNGOLOGY—Two Weeks Intensive Course will be offered starting September 14th. Clinical and Special Courses every week.

OPHTHALMOLOGY—Two Weeks Intensive Course will be offered starting September 28th. Five Weeks Course in Refraction Methods starting October 19th. Informal course every week.

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BOOK REVIEWS

THE ESSENTIALS OF APPLIED MEDICAL LABORATORY TECHNIC—J. M. Feder, M.D., Director of Laboratories and Allergic Service, Anderson County Hospital, Anderson S. C. Published by the Charlotte Medical Press, Charlotte, N. C. The manual is designed for the small hospital or office laboratory. As such, it fills a need not adequately met by the many larger volumes available. The technics presented require a minimum of time, space, and equipment, but are sufficiently wide in range to meet most clinical requirements. Unfortunately, in some cases accuracy has been sacrificed to convenience, and Dr. Feder's contention that "any laboratory worker who has mastered the technic of the orderly routine procedures" can learn from the book how to perform adequately the serodiagnostic tests for syphilis, will hardly find agreement from any recognized authority on the subject. The chapter on

preparation and transfusion of whole blood and plasma is terse but adequate, and for many will be one of the most valuable portions of the book. All material is presented in a format which facilitates easy reference, with many illustrations well integrated with the text. There is an adequate index. A. G.

THE 1941 YEAR BOOK OF PHYSICAL THERAPY—Edited by Richard Kovacs, M.D., Professor and Director of Physical Therapy, New York Polyclinic Medical School and Hospital; Attending Physical Therapist, Manhattan State, Harlem Valley State and West Side Hospitals, Visiting Physical Therapist, New York City Department of Correction Hospitals, Consulting Physical Therapist, New York Infirmary for Women and Children, Mary Immaculate Hospital, Jamaica, New York; Hackensack Hospital, Hackensack, New Jersey. Published by the Year Book Publishers, Inc., Chicago. Priced at \$3.00.

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THE DOCTOR AND THE DIFFICULT CHILD—William Moodie. Published by the Commonwealth Fund. Priced at \$1.50. Dr. Moodie, the Medical Director of the London Children's Guidance Clinic, has written a practical, readable book on a subject which is filled with many controversies. The first part, dealing with general principles; is the more valuable. In the second section where he deals with symptoms and syndromes, there is necessarily much overlapping. The case material, although brief, is well chosen and well presented. The book should be on the must list for school staff. E.S.

THE MODERN ATTACK ON TUBERCULOSIS—Henry D. Chadwick, M.D., formerly Superintendent of Westfield State Sanatorium, Tuberculosis Controller of the City of Detroit, Commissioner of Public Health of the Commonwealth of Massachusetts, Medical Director of Middlesex Tuberculosis Sanatorium, and Alton S. Pope, M.D., formerly Chief, Bureau of Communicable Diseases, Department of Health, Chicago; Deputy Commissioner of Public Health and Director of the Division of Tuberculosis, Commonwealth of Massachusetts. Published by the Commonwealth Fund, 41 East 57th Street, New York, 1942. Priced at \$1.00. Although little substantial progress has been made in the discovery of early tuberculosis, it is hoped that it can be eventually eradicated. Current problems of

tuberculosis are herein discussed, such as the operations of regional control programs and modern procedures especially with regard to the discovery and control of the disease. Health officers, public health nurses and other concerned with the disease problems will find this little book an aid in means of control and assistance in the eventual eradication of the disease.

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BOOKS RECEIVED

DISEASES OF THE SKIN—Frank Crozer Knowles, M.D., Edward F. Corson, M.D., and Henry B. Decker, M.D., Fourth Edition, published by Lea and Febiger, of Philadelphia, Pennsylvania. Priced at \$7.00. The volume contains 621 pages, illustrated.

ENDOCRINOLOGY, Clinical Application and Treatment—August A. Werner, M.D., F.A.C.P., Assistant Professor of Internal Medicine, St. Louis University School of Medicine; Associate Professor, St. Mary's Group of Hospitals; Physician Endocrine Clinic, Desloge Hospital and



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**Laryngoscope*, Feb. 1935, Vol. XLV, No. 2, 149-154. *Laryngoscope*, Jan. 1937, Vol. XLVII, No. 1, 58-60

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DIRECTOR OF MEDICAL SPECIALISTS, Certified by American Boards, 1942. Published by the Columbia University Press, Morningside Heights, New York. Priced at \$7.00. Since the first publication was issued the directory has been increased by 18,000 certified Diplomates.

THE EYE MANIFESTATIONS OF INTERNAL DISEASE—I. S. Tassman, M.D., Associate Professor of Ophthalmology, Graduate School of Medicine, University of Pennsylvania, Philadelphia, Attending Surgeon of Wills Hospital, Philadelphia, Pennsylvania. Published by the C. V. Mosby Company of St. Louis, Missouri. The book contains 542 pages and is illustrated.

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KANSAS MEDICAL ASSISTANTS SOCIETY

The following new officers were installed at the June 2 meeting of the Lyon County Medical Assistants Society held in Emporia: Mrs. Margaret Provost of Strong City as President; Mrs. Lyda Jones of Emporia as Vice President; Miss Mildred Thomas of Emporia as Secretary; and Miss Marjorie Madison of Emporia as Treasurer.

The Reno County Medical Assistants held a dinner meeting in Hutchinson on June 9. Dr. Etta Mundell of Hutchinson spoke on "The History of Medicine."

At the May 20 meeting of the Sedgwick County Medical Assistants Society the following new officers were elected: President, Miss Nina Wisler; Vice President, Mrs. Gretchen Moddrell; Secretary, Miss Dorothy Cipolla; Treasurer, Mrs. Marie Holman; Members of the Board of Directors: Miss Ruth Alton, Miss Ruth Funk, Mrs. Mary Elizabeth Hanes, Miss Georgia Roach, and Mrs. Eva Pedigo. One hundred dollars received from the proceeds of the hat check stand at the annual meeting of the Kansas Medical Society was given to the Red Cross. Miss Grace Booker of the Wichita Dairy Council, gave a talk on Nutrition, illustrated with movies.

The Shawnee County Medical Assistants Society installed the following new officers at a meeting held in Topeka on June 1: President, Mrs. Martha Cox; President-Elect, Miss Mary Hefner; Vice President, Miss Menell Larson; Treasurer, Miss Myrtle Coats; Secretary, Mrs. Virginia Kistler; Members of the Board of Directors, Miss May Evans, Miss Alma Engstrom and Mrs. Marjorie Euler. The annual picnic for the members of the Shawnee County Medical Society and their wives at which the members of the Shawnee County Medical Assistants Society are hostesses will be held on July 13.

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PRESIDENT'S MESSAGE

I have just returned from the national convention of the Woman's Auxiliary to the American Medical Association at Atlantic City feeling much inspired and enthusiastic about the year's work. It seems that the difficulties which we all are encountering while our country is at war has only served to knit us more firmly together and has made us more alive to our responsibilities.

I was gratified to find that the policies of the national organization for the coming year follow very closely the outline we had last year and which we had planned to carry through this year. Nutrition is to be the main theme and as I mentioned in the April Journal, "Every Doctor's Wife in Health Defense" will be our goal for the next twelve months.

All of us are busy with first aid courses, nurses aid, Red Cross work and other defense classes, but let us work as auxiliary units so we may not lose our identity.

The post convention issue of the bulletin will be published within a few days. Every county and state officer should have her subscription in before that time, as it will be her only contact this year with national chairmen. Send your order to Mrs. L. B. Gloyne, 1310 North Twentieth Street, Kansas City, Kansas, without delay.

We are all looking forward to a splendid year under the guidance of our National President, Mrs. Frank Haggard and I promised her the full support of every unit in Kansas.

Sincerely,
Mrs. C. Omer West

WOMEN'S AUXILIARY NOTES

The Women's Auxiliary to the Sedgwick County Medical Society closed its fiscal year with a picnic lunch at the home of Mrs. Allen Olson in Wichita. The following new officers were installed for the new year: Mrs. N. C. Nash as President; Mrs. W. P. Callahan as President-Elect; Mrs. C. C. Brown as Vice President; Mrs. H. E. Friesen as Recording Secretary; Mrs. Harold Hyndman as Corresponding Secretary and Mrs. Wilfred Cox as Treasurer. The following new committee chairmen were also appointed: Mrs. B. C. Beal as Historian; Mrs. R. H. Maxwell as Membership; Mrs. C. H. Dixon as Publicity; Mrs. D. W. Basham as Parliamentarian; Mrs. H. O. Anderson as Hygeia; Mrs. T. T. Holt as Social; Mrs. A. E. Bence as Public Relations; Mrs. E. D. Carter as Nominating and Mrs. A. L. Crittenden as Program.

The Women's Auxiliary to the Shawnee County Medical Society met at the home of Mrs. W. F. Abramson in Topeka on March 9. The assisting hostesses were: Mrs. H. W. Powers and Mrs. Harry Davis. Mrs. W. W. Reed gave a talk on "Red Cross Work in Civilian Defense". The following new officers were elected: Mrs. J. L. Latimore as President; Mrs. F. C. Beelman as Vice-President; Mrs. Vernon Wiksten as Secretary; and Mrs. Harold Morris as Treasurer.

The Members of the Executive Board of the Women's Auxiliary to the Sedgwick County Medical Society met in Wichita on March 8, at the home of Dr. and Mrs. G. W.

Kirby. Guests included the state officers of the Auxiliary and their husbands and the past-presidents of the organization and their husbands. Mrs. J. S. Hibbard was chairman for the meeting.

Instructions as to the special care of babies in the event of an air raid, based in part on the experience of London and other English cities, were made public today by the American Committee on Maternal Welfare.

In view of the general possibility of air raids on American cities, particularly in the coastal zones, the committee regards it as important that American mothers understand and prepare well in advance for the task of protecting their babies. The committee is composed of the leading medical, public health, nursing and hospital organizations of the country and can thus speak with authority.

Aside from the immediate need of shelter from bomb explosions, the most important fact to keep in mind, the English have learned, is that the mother's mental attitude is baby's best guarantee against air-raids.

"However frightened you may feel," the committee quoted from instructions issued by the British National Baby Welfare Council, "keep outwardly calm and unflurried, so that the child's confidence in your own protectiveness may not be shaken."

"Never speak of the raid in the child's hearing if you can avoid it. Mental impressions are formed very much earlier than most people realize. Many of the problem cases among grownups of the present day owe their condition to their parents having talked continually in the presence of the children about past and future air raids, about their own terror, and the effect of this on the child. The following words are as true today as when they were written thousands of years ago: 'In quietness and confidence shall be your strength.'"

When the raid signal sounds, the first move should be in the direction of the nearest shelter. If there is no shelter, take the baby to the safest room in the house, or to a closet under the stairs or under a table or bed, so that he may be protected from flying debris, which presents the most frequent danger.

Take with him garments enough to keep him warm according to the season, a basket or pillow on which he can lie, a first aid outfit in case of need; a toy to amuse him; his bottle of milk and bottle of water, together with extra diapers and related equipment.

The baby's ears should be blocked with cotton wool to minimize the effects of concussion, leaving plenty outside so that it may be easily withdrawn afterward.

If the raid should come while the baby is away from either house or shelter—for an airing in the park, for instance, find the nearest wall or ditch, however low, place the baby on the ground beside it, with pillows from the baby carriage or a heavy coat under and over him, and lie down beside him.



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SYNTHETIC ESTROGENS: THEIR FUTURE; THERAPY OF HYPOGONADISM WITH STILBESTROL*

Cyril M. MacBryde, M.D.**

St. Louis, Missouri

Estrogenic hormone therapy no longer lies entirely within the province of the gynecologist and the obstetrician. It is necessary that the general practitioner and the internist understand the conditions which will respond to treatment with estrogens. We should be prepared to give to women suffering hypogonadism therapy which will afford relief. The gonads are, of course, not only necessary for reproductive purposes, but furnish internal secretions important in the maintenance of normal health and vigor. Recent studies have shown that the metabolism and efficiency of muscle, for example, depend upon an adequate supply of the gonadal secretions. It is well known that loss of the internal secretions of the gonads leads to depression of the basal metabolic rate. The psychic disturbances which may result from loss of the gonads are severe. The appearance and body contours of the individual and one's ability to make his or her way in society depend largely upon the presence of normal gonadal secretions.

In this discussion we are concerned primarily with the female sex hormone furnished by the ovaries. It has not been so very long that we have understood the nature of the ovarian hormone. Modern conceptions of this problem may be said to date from the observation of Glass in 1899 that menstruation could be reestablished after bilateral oophorectomy if ovarian tissue were implanted into the uterus or broad ligament. In 1900 Knauer and Halban independently demonstrated that the atrophy of the genitalia known to follow oophorectomy failed to appear in rabbits and guinea pigs if ovarian tissue were transplanted into some abnormal site in the body.

It was thus conclusively demonstrated at the opening of the present century that an internal secretion of the ovary is necessary to the proper development and function of the sexual apparatus. Previous to this time it had been believed that menstruation was brought about by cyclic activity of the nervous system. This theory, pronounced by Pfluger in 1863, had been widely accepted, but these and similar experiments resulted in complete overthrow of the neurogenic hypothesis.

Many experiments followed which resulted in clarification of the nature of menstruation. The cyclic changes in the endometrium, demonstrated by Hitschmann and Adler in 1908, when correlated with the cyclic changes observed in the ovarian follicle and corpus luteum, provided a fairly satisfactory explanation of the mechanism of menstruation.

We were still a long way, however, from making practical use of this knowledge. Adler and Iscovesco in 1912 independently prepared active ovarian extracts which caused hypertrophy of the uterus and other female type sex changes. In 1917 Stockard and Papanicolau made the important observation that there occurs a cyclic change in the vaginal cells of the guinea pig during the various stages of estrus and anestrus. Long and Evans made similar observations upon the rat. In 1923 Allen and Doisy made practical use of the vaginal smears of rats to formulate a method of assaying the ovarian estrogenic principle. They used fresh follicular fluid obtained from hog ovaries. The amount of this ovarian extract necessary to produce active estrous changes in the vaginal smears of a castrated rat was called one rat unit. Only very small amounts of active ovarian extracts could of course be produced from animal ovaries. Each cubic centimeter of such material would probably have cost many dollars, so we were still a long way from applying any of this very interesting knowledge to actual treatment of the human female. In 1927, however, an observation was made which paved the way for a new era. In that year Aschheim and Zondek demonstrated the presence of the ovarian follicular type hormone in large amounts in the urine of pregnant omen. Since that

*Presented at the 83rd Annual Session of The Kansas Medical Society, Wichita, May 12, 1942.

**From the Department of Medicine, Washington University School of Medicine, The Washington University Clinics, and the Barnes Hospital, St. Louis.

time estrogenic hormones have been obtained primarily from pregnancy urine. In 1930 Doisy, Veler and Thayer obtained the hormone in crystalline form and named it theelin. It was around 1930 that the first practical use of theelin was made. Many remember the first ampoules of this material. There were fifty rat units in an ampoule, dissolved in water. Small wonder, with this low dosage, that early clinical results were disappointing.

Later observations have led to the conclusion that the true ovarian hormone is estradiol, and that estrone (or theelin) is an excretion product appearing in the urine, with only about one-sixth the activity of the original estradiol. Estradiol is made commercially by hydrogenation of the estrogenic hormones occurring in pregnancy urine and is now obtainable for clinical use. There are certain objections, however, to the use of the natural products estrone and estradiol. Although they are undeniably potent and clinically effective, (1) they are expensive, (2) they are relatively ineffective when given orally, and (3) they are difficult to prepare, and except when prepared in pure crystalline form, they must be biologically standardized. Because of these objections, many workers have been searching for years for a cheaper, orally effective, synthetic preparation which could be administered by the gram or milligram and not by the confusing system of rat and mouse and international units. The synthesis of a new estrogen which seemed to meet these criteria was announced by Dodds and his coworkers in 1938. It was named diethylstilbestrol because it was derived from stilbene, contained two ethyl groups and was estrogenic. It does not contain the phenanthrene ring nucleus previously thought to be necessary for estrogenic activity. It seems therefore to be quite unrelated chemically to the natural estrogenic hormones. The drug is called "stilbestrol" for short. It is about two and one-half times as potent as estrone when given by injection, which is remarkable enough, but most important of all, the synthetic hormone loses comparatively little of its effectiveness when given by mouth. When the natural hormones are taken orally, about ninety per cent of the hormone effect is lost, but stilbestrol by mouth loses only thirty to fifty per cent. It has proved to be very cheap when it is commercially produced.

In the relatively short time since the announcement of the synthesis of stilbestrol, there have been a large number of reports of its use in clinical and experimental studies. There is general agreement among most of the clinical observers that stilbestrol is a very potent estrogen which is capable of reproducing all of the known physiologic effects of natural estrogens and of relieving women suffering

from estrogen deficiency. A few observers have, however, reported a high incidence of untoward effects and have therefore questioned the advisability of its clinical use. Two years ago my coworkers and I published a summary¹ of our clinical and experimental studies up to that time. We had then had one and one-half year's experience with the drug. At that time we concluded that a high percentage of satisfactory therapeutic results were obtainable with stilbestrol, but that the drug should be further studied before being released for general use. We have recently reported our conclusions after another year's study³. Our own continued studies when correlated with those of others now permit certain conclusions not possible a year ago. In addition we have evolved a technique in the clinical use of stilbestrol which seems much superior to that previously employed. We now feel that stilbestrol is a highly effective estrogen, safe for human therapeutic use under careful medical supervision. I wish to present to you certain suggestions concerning its use which we have found practical.

Since March 1939 we have studied the response to stilbestrol therapy of 202 women with estrogen deficiency. One hundred and fifty cases are analyzed in this report, the rest of the cases not being observed over a long enough period for our purposes. Each of these 150 women has received diethylstilbestrol or diethylstilbestrol dipropionate intermittently or continuously over a period of at least three months. Eighty-four were suffering from symptoms of spontaneous menopause, fifty-eight from artificial menopause following operation or radiation, and eight were eunuchoid young women with amenorrhea and symptoms of primary hypogonadism. No patient was treated who did not fulfill these two criteria: (1) symptoms severe and characteristic of hypoestrinism; (2) and vaginal smears of the inactive castrate type. We no longer give stilbestrol by injection because it is so highly effective orally. Nausea was the only untoward symptom and this has become less frequent as we have used smaller and smaller doses. In addition to reducing the size of the dose, we have adopted the principle of interrupted rather than continuous treatment, which of course results in a much smaller total dose per month. Whereas the majority of our patients previously were given 1.0 mg. daily throughout the month, the majority now receive 1.0 mg. daily for two weeks, and treatment is then omitted for two weeks. Instead of twenty-eight mg. per month the average patient now takes fourteen mg. per month.

This principle of therapy was adopted for several reasons: (1) Prolonged excessive bleeding often occurred during the continuous therapy and was al-

most certain to follow sudden cessation of treatment. (2) The time of such bleeding could not be predicted. When the interrupted system is used, however, the artificial menstruation occurs from five to twelve days after the drug is stopped, and lasts from three to seven days as a rule. In older menopausal women in whom the resumption of bleeding is undesirable, the dose may be reduced so low that withdrawal bleeding does not occur. (3) Subjective improvement persisted throughout the month in the majority of patients in spite of the interruption of the medication. (4) The psychic effect of regular recurrent vaginal bleeding in the young castrates and primary hypogonadal amenorrheic patients is striking and gratifying. (5) The normal estrogen cycle is imitated by the interrupted treatment. Presumably interrupted estrogen therapy would more nearly simulate the normal ovarian effects upon the uterus and breasts and would reduce any tendency continuous estrogen therapy might have to stimulate neoplastic growth.

Since it has been suspected by some observers that liver disturbance might be produced by the synthetic estrogen stilbestrol, liver function tests were performed upon thirty-one patients who received the largest doses and who were treated for the longest periods of time. Repeated determinations were also made of the red blood cells, white blood cells, platelets, and hemoglobin. Urine examinations were done at frequent intervals. We have found no evidence that stilbestrol used in the doses we have employed will produce any toxic change in the liver, bone-marrow or kidneys. In animal work it has been shown that stilbestrol will cause anemia, thrombocytopenia and liver damage. My coworkers and I have recently shown^{2,4} that if estrogenically equivalent doses of the natural estrogens estrone and estradiol are given to dogs, that these natural estrogens will produce the same type and degree of toxic reaction in the liver, blood and bone marrow as stilbestrol. At present, then, the evidence would seem to indicate that stilbestrol is not any more toxic than other estrogens may be. So far neither natural nor synthetic estrogen has been shown to have toxic effects in women. The dose used in our animal work is from twenty-five to one hundred times as large per unit body weight as that we employ clinically. Overdosage in clinical use of this degree does not seem likely. The thought, however, should be kept in mind that overdosage with any of the estrogens might produce serious toxic effects.

The only objectionable result we observed was nausea. Patients receiving interrupted therapy had much less tendency to nausea than those receiving continuous medication. Of forty-five women receiv-

ing continuous therapy, nausea occurred in twenty per cent, while among 105 patients receiving interrupted treatment, nausea occurred in only nine, or 8.6 per cent. Relief of hypogonadal symptoms was as good as that obtained with comparable doses of natural estrogens. The improvement was striking as concerns hot flushes, emotional instability, headache and insomnia. Pruritus vulvae was relieved in twenty of twenty-six cases with this complaint. Increased libido and more satisfactory sex relations were reported by thirty-one patients. General improvement in strength and energy occurred in eighty-four of ninety-seven patients giving lassitude as a chief complaint. In summary of the 150 patients, only four patients had poor results, in eighteen the results were fair, and in 128 they were good.

We feel that the subjective results are more important than the exact degree of estrous response in the vaginal smear. When excellent relief of symptoms is obtained with a dose producing only a two plus or three plus vaginal smear response, we have found no advantage in increasing the dose until a four plus smear is produced.

I feel that authorities have been properly conservative in withholding this potent synthetic estrogen from unrestricted use. More time was needed before complete studies could be made. Stilbestrol has been obtainable in Canada and England for some time and recently has been made available for general clinical use in the United States. Sufficient information now has been obtained to lead us to conclude that stilbestrol should be used only for therapeutic purposes directed by the physician. It should be obtainable only upon prescription by the physician. The lowest doses giving good relief of symptoms should be employed. I feel that we stand upon the threshold of a great new era in estrogen therapy. It will no longer be necessary for the suffering woman to do without adequate estrogen treatment because of the great expense of the natural hormones. It will no longer be necessary for the physician to feel that he must deny relief to a large proportion of his female patients. Stilbestrol itself or some of its derivatives, or some other similar synthetic hormone will be available. No longer need we tell our patients "It's just the change of life. You may feel miserable for a few years, but you will probably live through it. Anyway, to give you relief I would have to give you at least two injections a week and the medicine itself would cost too much to make it practical." With a synthetic estrogen such as stilbestrol we can promise excellent relief. The medication is easily taken, and is effective in doses of one mg. or less per day when taken by mouth. Best of all, it will be in-

expensive and will be available to both rich and poor.

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BILATERAL GIANT FIBRO-ADENOMA SIMULATING MALIGNANCY IN PREGNANCY

H. Lester Reed, M.D.

A. E. Hiebert, M.D.

Wichita, Kansas

Enlargement of the breast in pregnancy is usual, fibro adenoma of small size is common and of large size not too rare, but bilateral giant fibroadenoma developing during pregnancy is rare. Because our case demonstrated rapid enormous growth and ulcerated, a false clinical impression of malignant change was entertained. We shall review the case and summarize the clinical entity.

CASE REPORT*

On September 9, 1941, a colored female, P. F., eighteen years old, entered the clinic complaining of large painful breasts and pregnancy near term. Present Illness:—This, the first pregnancy, had been normal in the patients opinion, (she had not had medical care to date), with the exception of breast complications. Three years prior, at the age of fifteen, she had noticed a small firm mass in the upper quadrant of each breast and these were pronounced "normal cartilages" by a school nurse. No change had occurred until the onset of pregnancy. The last menstrual period was December, 1940. In March, 1941, the right breast became large and lumpy with the "cartilage" also increasing in size. In July, the right breast began to grow even more rapidly and the left also participated with nodular increase in size. Some pain was present. Since that time the progress was by continuous enlargement, bilaterally.

Past History:—non-contributory. Family History:—not obtained. Physical and Laboratory Examination:—revealed a colored female not acutely ill, with a normal pregnancy approximately at term and

marked breast abnormalities. The right breast appeared four times normal expected size and was filled with very many firm nodules not attached to the skin, which was intact. The left breast was two times normal size and consisted of one large irregular firm mass containing two smaller discrete masses. One was two cm. in diameter and in the upper quadrant; the other was three cm. and lateral in the anterior axillary line. Skin intact. The left axilla contained one firm movable non-tender mass two cm. in diameter. Diagnoses:—Pregnancy near term, bilateral fibroadenoma and mastitis. The course decided upon was that of observation until following delivery.



Fig. 1

1. Patient. Giant right breast ulcerated.

On September 17, there occurred in the home an uneventful labor resulting in the spontaneous delivery of an eight and one-half pound female child which appeared normal and did well. On September 20, the patient was admitted to the hospital. T—100 P—100 R—twenty. The uterine involution was in normal course, however, the breasts while little changed grossly, caused much local pain. Laboratory examination revealed albumen, few leucocytes and coarse granular and hyaline casts in the urine, RBC 4.0 mil, Hb seventy-eight per cent (Sahli-Hellige), WBC twelve, 250, Differential Baso. two, Eosin. eight, Lymph. thirty-two, Young. four, Bandf. eight, Seg. forty-two, Mono. four. The management included ice packs, sulfathiazole and narcotics. For the following nine days the breasts remained unchanged and the general state was a moderate febrile one with the temperature remaining about 101 degrees, until on September 29, the patient desired no further care and left the hospital. She was next seen October 9, at which time she returned with the story that in the interval the swelling had increased bilaterally, the right breast had ulcerated through the skin and the local pain increased. T. 98.2, P-eighty,

*From the Dept. of Pathology, St. Francis Hospital, Wichita, Kansas, and the Surgical Service (A. E. Hiebert, M.D.) of the Sedgewick County Hospital, Wichita, Kansas.

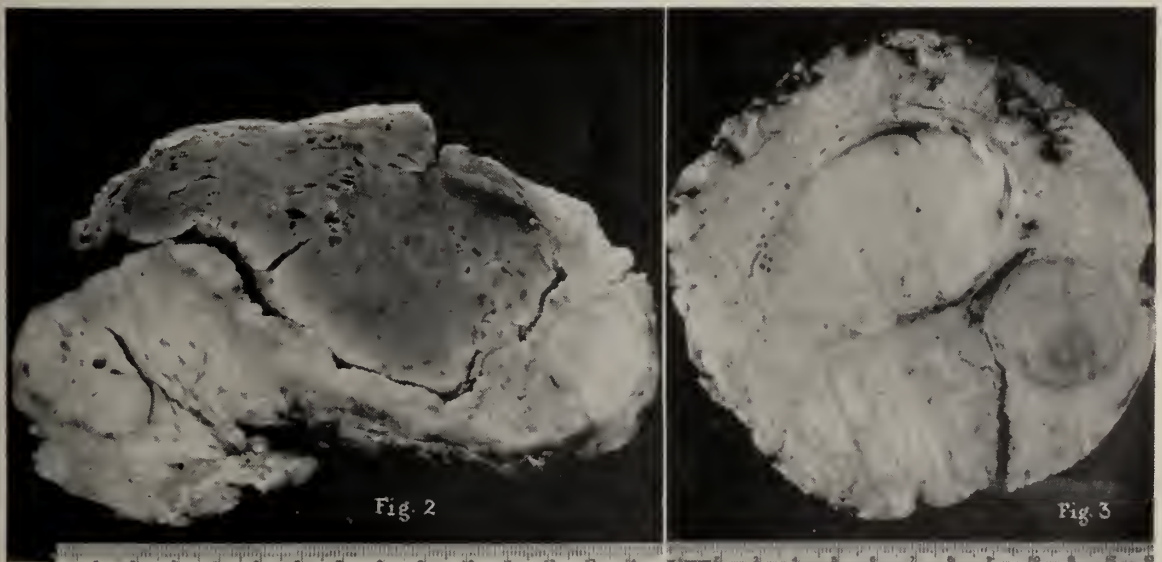
R-twenty. Examination revealed ulcerated fungating mass from right breast and left breast under tension so that ulceration seemed imminent. Malignant change was strongly suspected by numerous consultants at this time. RBC 4.0 mil., Hb seventy-three per cent, WBC 13,000, normal differential.

On October 16, right simple mastectomy was performed under general anaesthesia. The post operative course was uneventful. On October 27, left simple mastectomy was likewise performed under general anesthesia. The post operative course was again uneventful and the patient was dismissed from the hospital November 5, with a small amount of serous drainage from the right chest incision. On November 22, the out-patient department dismissed the patient with healed incision. Follow up in the Tumor Clinic, March 24, 1942, showed well healed incisions and no recurrence.

Description of specimens: Right—Gross examination reveals large breast without axilla, with nipple which appears normal and which contains an ulcerating spherical tumor eleven cm in diameter which protrudes three cm over the skin surface. The cross section shows a circumscribed, encapsulated, necrotic mass eleven cm in diameter and a smaller encapsulated tumor 4.5 x 3.0 cm in diameter. Microscopic examination shows necrosis and acute inflammation. Some areas show marked acinar proliferation with little connective tissue. The epithelium is cuboidal and the cytoplasm contains globules (fat) typical for lactating breast. At the periphery of such a lobule, atypical proliferation of epithelial cells is seen, but no definite malignant features are

present. The stroma contains many round cells. The capsular portion shows many irregular whorls of adult connective tissue cells and a few glandular element typical for fibroadenoma, pericanilicular. Diagnosis:—benign giant fibro adenoma with necrosis in lactating breast. Left—gross reveals breast without axilla, measuring twelve by twelve by five cm. The cross section shows two circumscribed tumors of yellowish color, five and three cm in diameter, and several cysts less than two cm, filled with whitish creamy fluid. Microscopic shows features similar to the opposite except that necrosis is less marked and the lobular development of lactation is better preserved. Atypia is present. Diagnosis:—same as opposite breast.

Fibroadenoma is a clinical entity which is seen often. It is usually a small to moderate sized, single, firm, movable tumor in one breast of a young woman. Pain is unusual, growth is slow and malignant change rare. Chronic cystic mastitis and cancer are not ordinarily confused with it. Grossly, the tumor can be easily shelled away from the adjacent breast tumor, is encapsulated, and on the cut section bulges. It is firm, pearly white and rarely cystic. Histologically two types are seen, intracanalicular and pericanilicular. The first shows much adult fibrous tissue covered with a thin even layer of cuboidal epithelial cells, explained by the marked periductile connective tissue proliferation which encroaches on the lumen of ducts and pushes epithelium ahead of it. The second shows a predominance of epithelial proliferation with ducts the more and stroma the less active components respectively. The tumor ap-



2. Cross section right breast specimen. One large necrotic encapsulated mass, and one less in size and viable. 3. Cross section left breast specimen. Two encapsulated tumors.

pears rarely before menarche and a new fibroadenoma developing after the menopause is unusual. That an endocrine factor is in operation in production of this tumor is apparent from both clinical and experimental observations. Clinically, the age of occurrence coincides with that when gonadal activity is great. Hertzler² points out and illustrates the increase in size of the tumor in pregnancy and shows that the histology is the usual acinar proliferation and secretory increase of pregnancy occurring in the glandular structure of the tumor proper. Experimentally, Mohs et al^{4,5} noted that rat adenofibroma transplants take better and grow more rapidly when the host is supplied with normal or increased estrogenic substances and conversely, that once the tumors are established regressive changes to pure fibroma result from administration of androgenic substances.

The usual clinical course of the lesion is progressive, for many years by slow enlargement; then by rapid growth with rare, if ever, complete regression. Occasionally the tumor is of so great a size as to be termed "giant fibroadenoma" or less commonly and more properly, "Cysto sarcoma phyllodes." This special state is well summarized by Owens and Adams⁶. General opinion classifies this special lesion as practically always benign. In contrast, White⁸ reported a case of a thirty-four years old single woman with a tumor diagnosed cysto sarcoma phyllodes, recurring in four months and proceeding to death in nineteen months with pulmonary metastasis which were definitely sarcoma. Harrington and Miller¹ believe that any fibroadenoma may become malignant and advise excision of all. In their study of malignant change in thirty-nine such tumors, the grade malignancy was usually low and surgical result good, the diagnosis in fifteen carcinoma and twenty-four sarcoma. Of the former nine, and the latter fourteen, were

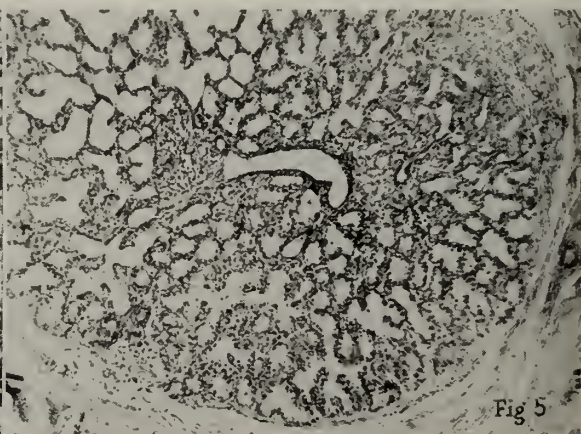
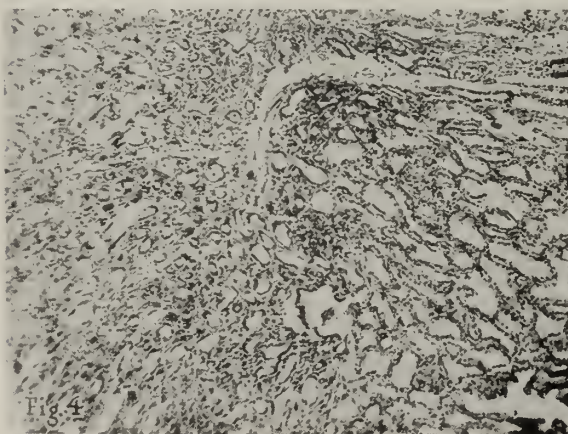
well five years after simple mastectomy. The earliest age of onset of malignant change in this group was thirty-one years. Markowitz et al³ point out an instance of a rapid growth of a fibroadenoma in a girl age fourteen. Stark⁷ presents his case of a large unilateral fibroadenoma at the age of forty-four, which was removed and followed in the next seven years by two recurrences in the original breast and by appearance of a similar tumor in the opposite breast, the later tumor recurring three times, the last specimen being of no more malignant character than the first.

COMMENT

The features of this case seem clear at this time. The patient had bilateral fibroadenoma which appeared at the age of fifteen, a not uncommon feature. These tumors caused no added symptoms until the first pregnancy at the age of eighteen. At this time probably two factors were active in causing enormous growth and ulceration. First, the normal stimulation of breast tissue by pregnancy, resulting in proliferation and secretion appeared. Second, the ever present growth tendency of the tumor tissue became more active. Necrosis occurred because the tumor outgrew its blood supply and ulceration resulted from increased skin tension and ischemia. With ulceration, there were many clinically who believed the tumor malignant. That such was not likely is shown by the work of Harrington and Miller¹, in which fibroadenoma were reported to undergo malignant change only after the age of thirty.

SUMMARY

1. A case of giant fibro adenoma, bilateral, in pregnancy is reported. A colored female who first noted bilateral small fibroadenoma at the age of fifteen, with her first pregnancy developed enormous enlargement bilaterally. This became so marked at



4. Microscopic, right breast. Atypical proliferation at periphery of a viable lobule. 5. Microscopic, left breast. Well marked lobular structure of lactating breast.

term as to ulcerate and cause unwarranted suspicion of malignant degeneration. Simple bilateral mastectomy was performed, the diagnosis pathologically of giant fibroadenoma, bilaterally, with ulceration and lactation was made. Five months follow up with no recurrence is reported.

2. The clinical and pathological features of fibroadenoma, usual and unusual, are summarized.

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Whatever its drawbacks, total war is not open to the same eugenic objections as the old-fashioned kind. It has been said of wars in the past that they destroy the cream of the young manhood of a generation; and that the best germ-plasm is thus irrevocably lost, to the lasting detriment of the race. To see men in terms of germ-plasm savours, perhaps, of the biologist's fancy that the hen is merely a device for producing more eggs; but the argument is disturbing for all that. To know that this dysgenic effect is reduced, because the risk is more evenly distributed, is a minor consolation of this war. Raymond Pearl, however, held that no war had so far occurred in the nineteenth or twentieth century which had had any measurable genetic effect on the nations involved. This seems incredible until his figures are studied. He pointed out that wars, nowadays, last only a short time in comparison with the span of human life; and more fighters return than are killed. They return in the prime of life, capable even if maimed of founding healthy families; and most of them do. In the last war those killed formed a startlingly small fraction of the total population. He estimated that the loss to the American race was only 0.055 per cent of the 1910 population, or 0.048 per cent of the 1920 population, and thought it unlikely that any geneticist would regard five one-hundredths of one per cent as a significant loss from the total gene pool of the population. The comparable figure for France was, of course, much higher, lying, he calculated, somewhere between 1.4 and 3.4 per cent of the population; yet even so it could have had no measurable effect on the quality of the French race. These figures are worth remembering at the present time, when pressure of war spoils the sense of proportion. Nor is it merely on genetic grounds that they are cheering; they remind that, at worst, wars are minor interruptions of our evolution and that we have a good chance of growing out of them.—The Lancet.

THE TREATMENT OF ULCERATIVE COLITIS WITH NISULFADINE AND NISULFAZOLE

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In a previous communication¹ mention was made of the possible therapeutic application of 2-(p-Nitrobenzenesulfonamido)-Pyridine. This compound when taken by mouth is converted in the intestinal tract, partly into sulfapyridine, which should appear locally in considerable concentration with the probable formation of other reduction compounds. More recently we have studied the therapeutic effects of a similar compound, 2-(p-Nitrobenzenesulfonamido)-Thiazol.

Both of these compounds are relatively insoluble, the solubility of 2-(p-Nitrobenzenesulfonamido)-Pyridine* being less than one mg. per cent at twenty degrees C, while that of 2-(p-Nitrobenzenesulfonamido) Thiazol* is also less than one mg. per cent at twenty degrees C. 2-(p-Nitrobenzenesulfonamido)-Pyridine melts with decomposition at 192-3 degrees C; 2-(p-Nitrobenzenesulfonamido) Thiazol melts at 280-1 degrees with decomposition. For the purpose of simplification, 2-(p-Nitrobenzenesulfonamido)-Pyridine will be referred to as Nisulfadine, while (2-p-Nitrobenzenesulfonamido) Thiazol will be referred to as Nisulfazole.

While both of these compounds show a resemblance in their lack of solubility, their behavior in the human body apparently differs. When a patient receives Nisulfadine by mouth, the blood level of sulfapyridine rises much higher than Nisulfadine

TABLE I

Blood in Mg. Per Cent

Date	Sulfapyridine*	Nisulfadine	Date	Sulfapyridine*	Nisulfazole
9-4-41	5.75	2.9	2-27-42	1.1	6.1
9-6-41	4.3	1.5	3-3-42	0.7	6.1
9-8-41	2.3	2.0	3-6-42	0.8	6.7
9-10-41	4.05	1.8	3-11-42	0.8	6.2
9-15-41	4.7	3.6	3-13-42	1.0	5.8
9-17-41	6.35	2.45	3-18-42	1.6	8.4
9-20-41	7.9	3.2	3-21-42	1.5	9.2
Patient received during this period an average dose of 3 gm. Nisulfadine daily.			Patient received during this period 4 gm. Nisulfazole daily.		

*Values calculated as sulfapyridine and sulfathiazole. Actually known only as compounds containing amino groups giving the characteristic color reaction with sodium nitrite.

*Supplied through the courtesy of George A. Breon and Company.

**From the Department of Internal Medicine, University of Kansas School of Medicine, Kansas City, Kansas.

TABLE II

Name	Sex	Age	Admit	Dismiss	Duration Before Treatment	Proctoscopic	X-Ray	Blood on Admission	Number Stools Daily	Drug	Length of Treatment	Result	Relapse	Remarks
V. M.	M	23	7-28-41 1-2-42	12-14-41	14 mos.		9-9-41 Advanced Ulceration 3-16-42 Marked Improvement	RBC 32800000 WBC 10700 Hb 45%	7-28-41 14 12-12-41 2 1-2-42 7 2-14-42 1	Nisul-fadine Nisul-fazole	5 mos. 3 mos.	Recovery Recovery	Yes	Diarrhea recurred two weeks after discontinuing drug. Drug treatment discontinued 4-9-42. Still under observation.
H. P.	M	71	6-23-41	7-21-41	18 mos.	6-25-41 Ulceration	6-25-41 Ulceration	RBC 4060000 WBC 7500 Hb 85%	7-21-41 10 7-20-41 1	Nisul-fadine	1 mo.	Recovery	No	Weight increased from 117 to 121 pounds during treatment.
D. F.	M	16	6-30-41 9-22-41	7-19-41 10-4-41	4 mos.	7-1-41 Ulceration 9-23-41 Small Ulcers		RBC 3360000 WBC 5600 Hb 63%	6-25-41 4 7-18-41 2 10-2-41 2	Nisul-fadine Nisul-fadine	3 weeks 13 days	Recovery Recovery	Slight No	Weight increased from 93 to 98 pounds during treatment.
R. T.	F	19	1-9-42	4-2-42	9 mos.		1-10-42 Active Ulceration 4-1-42 Marked Improvement	RBC 3610000 WBC 10000 Hb 60%	1-9-42 10 2-9-42 2	Nisul-fadine Nisul-fazole	4 weeks	Recovery	No	On two occasions discontinuance of treatment for 4 days followed by diarrhea.
V. R.	F	22	2-13-42		5 mos.	4-2-42 Marked Congestion	2-14-42 Ulcers	RBC 3520000 WBC 15000 Hb 42%	2-13-42 27 4-2-42 3	Nisul-fazole	6 weeks	Recovery		Still under observation. Drug therapy discontinued 3-24-42.

level, but when Nisulfazole is administered by mouth the reverse is true. A typical series of observations are shown in Table I, all made on the same patient.

These two drugs were employed in a variety of infectious diseases including those of the intestinal tract. The results in ulcerative colitis seem promising.

Five cases of ulcerative colitis were treated during the past year with encouraging results. Several other cases of diarrhea were also treated successfully, but not presenting the classical picture of ulcerative colitis, were not included. The cases summarized in the following table all showed either by proctoscopic or x-ray examination the classical picture of ulcerative colitis.

While Nisulfadine often caused nausea after a few days administration and had to be discontinued for twenty-four hours or longer, Nisulfazole produced little or no nausea even in large doses. Patients tolerated six to eight grams of Nisulfazole daily without nausea. No toxic symptoms were observed after administration of either drug, with possibly one exception. Patient V. R. received Nisulfazole gm. 1.0 twelve days after this drug had been discontinued. This single dose apparently caused a sudden elevation of temperature accompanied by nausea and much intestinal discomfort. This reaction was apparently the same as those described by Lyons and Balberor², who observed that thirty-six per cent of their patients developed febrile reactions after the re-administration of sulfathiazole.

Improvement in the patients' symptoms, disappearance of nausea, reduction in the number of stools, usually occurred in the first few days after treatment was instituted. In some instances striking improvement appeared within the first twenty-four hours.

We realize that chronic ulcerative colitis is a disease, subject to exacerbations and remissions and that a great variety of therapeutic procedures of benefit in this disease have been described. Our cases received no specific medication save the two compounds, Nisulfadine and Nisulfazole. All were placed on a bland diet with a minimum of residue and three patients received blood transfusions. Case VR, the most severe of the group, received no blood transfusions until the diarrhea had ceased.

Our experience with these two compounds in the treatment of chronic ulcerative colitis, indicates the desirability of their further clinical study.

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PUBLIC HEALTH AND THE WAR EMERGENCY IN KANSAS

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The war emergency and the great changes it has brought to community life in many parts of Kansas have impressed forcibly upon the minds of thinking citizens the undeniable fact that health is a factor which very definitely conditions our success in all undertakings, individually or collectively.

This was demonstrated in dramatic fashion a year ago, by the rejection of thousands of Kansas selective service youth because of physical defects or disease, in many cases such disabilities being unknown to the selectee himself. For venereal disease alone, up to June 15, 1942, 1595 (approximately five per cent) young men were turned down by the armed services. Diseases of the lungs caused the rejection of approximately 800, as of the same date, although this figure is provisional. Defective teeth accounted for 13.7 per cent of all rejectees; mental and nervous diseases, 11.8 per cent; defective ears, 4.6 per cent; defective eyes, 11.9 per cent; musculo-skeletal diseases and hernia, 9.1 per cent; cardio-vascular diseases, 10.3 per cent. Other causes accounted for 29.5 per cent.

In the protection and promotion of the public health, there is no substitute for scientific knowledge. A community which possesses this virtue functions on a basis which enables it to cope successfully with new problems arising in the field, regardless of whether they have their origin in the war emergency or in the routine of undisturbed daily life.

In the present war emergency, Kansas communities, particularly those which are centers of the war projects, are undergoing sudden and drastic changes.

Hardly a phase of life in these communities is the same today as it was yesterday. Instead, the routine has shifted from a once simple and easy going procedure to a pressing and complex social problem, which has its roots in the influx of transient worker-families and in the accompanying economic and general health dilemmas which demand a solution at the onset.

Unlike sugar, rubber, gasoline and hundreds of other articles which figure in our daily lives as Americans, public health cannot be rationed. But it can be regulated.

It must be regulated now, more than ever before, if the all-out picture of successful war effort in Kansas and in the nation is not marred by the

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shadow of disease, illness, and death by epidemics.

Never before in the history of public health work have the men and women engaged in this field been called upon to do so much in so little time.

Each Kansas community which houses a war factory or plant has become a theatre of war for the public health workers—a field of battle against sudden and violent outbreaks of disease. The battle goes on twenty-four hours a day for protection of public health and safety; for the uninterrupted continuation of our war effort.

At Wichita, at Parson, in Kansas City, and soon at Eudora, and other points, complete and thorough departures from the former way of life have been brought about by the construction of war production plants and factories. In most instances the change was abrupt; there was little time for preparation; there was little opportunity to plan; there was nothing to do but to accept the problem and to begin the task of its successful solution, for we can have no failures where the health and well-being of our war workers and our citizens are concerned.

Each of these towns suddenly, almost overnight in fact, saw its population increased by as much as 30,000 or 40,000 persons in some instances, with all the attendant sanitation, public health and medical care problems doubled by virtue of the fact that the population increases represented, for the most part, family units with children to care for, and to protect from wrong environment by proper day care.

Row upon row, block upon block stand the trailer homes and temporary housing facilities in these defense towns. Trailer cities sprang up over night. Quick construction resulted in hundreds of small houses being readied within a short time for the shelter of transient families anchored at last to a job.

Sanitation became a difficult problem. Proper disposal of sewage became an immediate necessity. Adequate day care for hundreds of children left alone while their parents worked in plant or factory became a problem demanding immediate solution. The obligation to assure pure foods entered the picture. Proper quarantine measures to protect workers and their families from disease had to be taken wherever contagion appeared. All in all, a mountainous task!

Recognizing the immediate need for strict regulatory measures, the Kansas State Board of Health rigidly concentrated its emergency regulations pertaining to proper sanitation in defense areas. Regular inspections were made. Special attention was paid to food and places where food was served. Housing facilities were given a sharp going-over and measures designed to prevent the spread of conditions tending toward a poor moral environment were invoked.

The Board's Division of Child Hygiene placed special emphasis upon the enforcement of a twenty-three-year-old State statute governing maternity homes, and homes where children are cared for in the absence of parents or guardians. Kansas law gives the Board of Health the power and authority to license these homes and to close any such institution not meeting requirements as established by the Board.

Meanwhile, all agencies of the Kansas State Board of Health immediately went on the alert as a part of their routine duty in safe-guarding the public health. Close cooperation with federal agencies was inaugurated and has been a policy adhered to strictly in all activities centering in the defense zones.

The question of morale, and its effect upon workers and townspeople alike entered the picture as an important angle in the public health field. Proper recreational facilities were seen as necessities and conditions leading to vice or any adverse moral environment, the Board decided, must be eliminated as soon as they developed.

As a necessary part in this picture of interlocking public health obligations, the State Board of Health urged all counties to consider seriously the effectiveness of full-time county health units geared to the highest possible pace in keeping abreast of the times in safeguarding public health and safety.

Many of the problems and difficulties arising in Kansas today will not eliminate themselves in a short period of time. Many of them will become common to many communities, particularly those whose population is expanding and whose industrial life is increasing in momentum.

With these things in view, all Kansas counties of 20,000 or more population should look to the full time county health unit as a necessity. They should investigate the possibilities in health for their communities and ascertain what can be obtained by the operation of such a unit, capably directed and staffed.

Such counties should make provision in their levies for maintenance of a full time health unit and should draw up their rules and regulations governing emergency situations before they strike.

Experience has proved that the full time health unit is the only answer to correction of public health problems in communities. Routine health activities and public health programs, based upon the individual, the family or community group, and the schools group are vital factors in the successful effort of a community to maintain health and to combat disease.

In short, the position taken by the State Board of Health was the immediate adoption of plans calling for the most effective utilization of Kansas resources in medical, nursing and public health services.

All agencies of the Board have dedicated themselves to this task, feeling, that in times of war emergency particular, the public has the right to know that a specialized staff is working twenty-four hours a day if need be to protect its safety, to safeguard its health and to keep down any spectre of disease.

Kansas physicians have lent their time and effort toward close cooperation with public health workers, assisting the State immeasurably in keeping abreast of the ever changing public picture. Their farsightedness in predicting problems to be solved, and their initiative in starting machinery working toward a solution of those potential problems was an inspiration to those charged with outright performance in the field.

That a decline in pneumonia deaths during an influenza epidemic occurred, for the first time on record, during the winter of 1940-1941, is announced by statisticians of the Metropolitan Life Insurance Company. A minimum figure for pneumonia deaths below which a further considerable reduction is unlikely is being approached, as indicated by these studies. Fatal pneumonia cases are now concentrated in young children and comparatively old people. Many of the deaths, about one fourth in the opinion of attending physicians, were due to complicating diseases. Sulfa drug treatment seems to have largely replaced serum treatment. Sulfathiazole was the favorite drug last winter, but sulfadiazine is likely now to be used far more widely. Bacteriological studies to determine the germ responsible for the pneumonia in each case seem to have been largely abandoned in urban centers.—Science.

Plans for the mass production of tetanus toxoid are under way at the Michigan Department of Health laboratories. It is estimated that 100,000 doses will be manufactured as an emergency measure to protect workers in the state's war industries against the disease.

Initial pilot runs of the toxoid have been made to determine its effectiveness and these have been very satisfactory. Large scale production will not be possible, however, until special equipment and adequate quarters can be obtained. Purchases are now being made for the equipment and a building is being constructed.

The manufacture of tetanus toxoid is a slow process. Several stages are involved, some of them taking weeks before they are completed. Every effort is being made to make large quantities of the toxoid available at the earliest possible date.

First use of the toxoid will be made among workers in those factories which would probably be targets for enemy bombers.—Michigan State Medical Journal.

Armati, an Italian of Florence, was said to have invented glasses in 1285. On his tombstone in Florentine churchyard was found the inscription, "Here lies Salvino del Armati of Florence, the inventor of spectacles. God forgive him his sins. Died in the year of our Lord 1317."—The Military Surgeon.

ROENTGENOGRAPHICALLY DEMONSTRABLE CAUSES OF CYANOSIS IN THE INFANT AND NEWBORN

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I want to bring to your attention several of the causes for cyanosis in the infant and newborn which can be demonstrated and diagnosed by the roentgenographic examination.

We will consider cases up to eighteen months of age but the greater number of cases will come in the newborn period, the first month or two of life. All cases with the exception of one, which is a normal infant, had at some time during the course of their life cyanosis as one of their chief symptoms or signs, as the case may be.

In our experience the commonest roentgenographically demonstrable cause of cyanosis in the newborn is congenital heart disease. In these cases we see on the anteroposterior x-ray film and fluoroscopically a heart larger than normally seen in overall dimension and in transverse diameter. It is often globoid with overprominence of either the right or left silhouette or both. The upper central shadow is usually not wide. Cardiac pulsation as observed fluoroscopically is often of low magnitude.

Clinically a heart murmur may or may not be heard. In one group of congenital heart disease cyanosis is a prominent sign due to the admixture of oxygenated and unoxygenated blood as the result of an arteriovenous shunt. The tetralogy of Fallot is the commonest congenital heart in this group. It consists classically of: (1) pulmonary stenosis, (2) dextroposition of the aorta, (3) interventricular septal defect, and (4) hypertrophy of the right ventricle. In the radiograph of the tetralogy the hypertrophy of the right ventricle without the pulmonary conus gives the wooden shoe or "coeur en sabot" contour.

It has been stated that a high percentage of cases of congenital heart disease, perhaps around fifty per cent, show no change from the normal contour on the x-ray film, so that many of the cases of congenital heart are not diagnosed in infancy radiographically.

I wish to discuss three cases of congenital heart, one diagnosed during life and proven at autopsy to be the tetralogy of Fallot, the other two belonging to the group causing cyanosis.

The second most common roentgenographically demonstrable cause of cyanosis in our experience is the somewhat controversial enlarged thymus which

when it produces pressure on the trachea and great vessels causes cyanosis. The two cases which are in my opinion thymus hypertrophies which caused spells of cyanosis and in the one case death are presented. It is not infrequent in the roentgenologist's experience to see chest films of infants which show in the A. P. projection an enlarged thymus shadow and when the case is investigated find that no history of cyanosis or dyspnea exists. These undoubtedly represent the large flat thymus gland not causing pressure. In fact, Helen B. Taussig at Johns Hopkins states that a supposedly pathologically wide supracardiac shadow is present in from twenty-five to fifty per cent of well babies. This estimate seems to me to be a trifle high.

The diagnosis of enlarged thymus gland causing symptoms then rests on the clinical presence of spells of cyanosis and the radiographic demonstration of a wide upper mediastinal shadow often having the lobulated outline to be shown later. It is not always possible to eliminate a congenital heart. The enlarged thymus gland can be reduced in size by the therapeutic application of roentgen ray in suitable small doses.

Congenital diaphragmatic hernia is not a common cause of cyanosis, but I will present two cases proven to be congenital hernias through the left diaphragm. It is easy once one is familiar with the picture of this condition to diagnose it from the x-ray film of the chest and abdomen of the infant, as was done in these cases. In our cases cyanosis was a major sign. Death, when it occurs, is often by asphyxiation. The symptomatology is often entirely related to the respiratory system because of compression of lung tissue and the mediastinum. Congenital diaphragmatic hernia is in the majority of cases on the left, due to a persistent hiatus pleuro-peritonealis, the result of failure in fusion of the posterior and lateral segments of the diaphragm. It can occur on the right. Any or all of the abdominal organs may slip through the opening in the diaphragm into the thoracic cage. Early surgical repair is a life-saving procedure.

Agensis of the lung is a rare cause of cyanosis in the infant, only thirty-nine being reported in the literature up to 1939. It is difficult of diagnosis from the roentgenographic appearance, the correct diagnosis being usually made at autopsy. Anatomically a rudimentary fragment of lung tissue may be present or there may be complete absence of lung. The bronchus on the one side, if present, is small. Pulmonary vessels to the affected side are absent. The remaining lung is often hypertrophied. The heart and mediastinum may be displaced to the side of the thorax from which the lung is absent, giving the roentgen picture of massive atelectasis of one lung. The small and large intestine or the liver with a

high undescended diaphragm may occupy one-half of the thorax. I will discuss one case of this condition.

Spontaneous pneumomediastinum in the newborn, of which we have one case and have seen a second, must be considered in any case of cyanosis in the newborn as cyanosis is the cardinal sign in this condition. It is a collection of air in the mediastinum, varying in amount and tension, which arrives there by way of the perivascular sheaths of the lung from ruptures of the alveolar bases. That this is the pathogenesis has been fairly conclusively shown by C. C. Macklin of the University of Western Ontario experimentally on animals.

The morbid physiology of pneumomediastinum is a pressure on the great vessels with vascular congestion resulting in dyspnea, cyanosis, and fall in blood pressure. The air may extend from the mediastinum into the neck, retroperitoneally, or into the lung opposite that from whence it came. A pneumomediastinum of severe degree can result in death, as it did in a child in Macklin's series. Treatment of the condition, if severe, is relief of the air pressure with mediastinotomy.

Large tumor masses in the neck, such as the cystic hygroma or teratoma, can by their presence and proximity to the trachea cause intermittent obstruction of the trachea with periods of cyanosis. In a like manner retropharyngeal and upper mediastinal abscesses by their forward displacement of the trachea can be a cause of cyanosis and respiratory difficulty.

Persistent atelectasis or congenital atelectasis in the newborn is that condition in which expansion of the lungs which is normally complete in two to three days of life has not occurred. The most characteristic finding is cyanosis often in attacks. It occurs in infants who are too weak to make the necessary respiratory effort. The x-ray shows irregular linear shadows usually at the bases or a lack of aeration of one or more lobes of the lung.

Cyanosis is often a sign in pneumonia in the infant but, as such, is of minor significance. The radiograph is of considerable help in the diagnosis of pneumonia in the infant, both as to the type and extent of involvement.

In reviewing the last six consecutive cases of foreign bodies in the lung in babies less than eighteen months of age, I found that cyanosis was present in only one case. In this case, however, it was severe in degree and the radiographic findings were a ball valve obstruction of the right main bronchus with atelectasis of the left upper lobe of the lung. The cyanosis was relieved following the removal of the foreign body. Five of the six cases of the obstructions studied were of the ball valve type with hyperaeration of the lung on the obstructed side, thus accounting for the lack of cyanosis.

"DYSPEPSIA" DUE TO POLYPS OF CERVIX

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Small benign tumors growing within the cervix may cause distress suggesting colitis, gall bladder disease, or some other variety of dyspepsia without leukorrhea, abnormal bleeding, or other sign of pelvic disorder. Careful digital and speculum examinations and proper treatment will benefit the patient far more than therapeutic tests of various medicines for dyspepsia or extensive x-ray investigations. It was explained to each of the following patients that she should be re-examined after a few months as the simple procedure done in the office might not result in a permanent cure.

CASE ONE

A married woman, aged forty-three, who had borne one child, had had cramping pain in the lower abdomen for several months. This was without relation to meals or type of food eaten, but was worse after she had been on her feet a good deal and before her menstrual period. She thought the distress began following a common cold. Druggists had advised various pink and white liquid preparations, none of which had relieved her symptoms. General physical examination was entirely negative. A soft red endometrial polyp protruded from her cervix. This was grasped at its base with a forceps, twisted off, and the base cauterized. Her cramping ceased immediately.

CASE TWO

A single woman, aged thirty-five, had suffered for two years with gradually increasing indigestion characterized by mild cramping pains around the umbilicus. This was not related to the time or type of food ingested, but was definitely worse before and during menstruation. Her menses were regular, occurring about every twenty-eight days, lasting four or five days. She did not have leukorrhea between periods. Except for the pelvis, general physical examination, urinalysis, and blood tests for syphilis were negative. Since she had been told by physicians elsewhere that her symptoms indicated disease of the gall bladder, roentgenograms were made after oral administration of the dye. These showed a normally functioning gall bladder without stones. At the time of first examination, digital examination of the pelvic organs seemed to be normal. After inserting a speculum in the vagina, a typical red endometrial polyp about one and one-half inches long was seen protruding from within the cervix. This polyp was grasped at its base, twisted off, and the base cauterized. When examined five days later, she stated that she had had no further indigestion from the time that the polyp was removed. This was reaffirmed in a letter three months later.

CASE THREE

A nulliparous white woman, aged thirty-three, had had for several years a gradually increasing abdominal distress characterized by gas and a feeling of distention in the abdomen. Except that these symptoms were worse just before and during menstruation, her periods were normal. Several physicians had told her that she had nervous indigestion. After roentgenograms of the colon she had been

treated for some time for spastic colitis. When first seen by me, physical examination was entirely negative except for the pelvis. The uterus was freely movable and did not seem to be enlarged. The cervix felt somewhat irregular. Masses or tenderness could not be felt in the adnexal regions. When the speculum was inserted a fibrous polyp was seen, about three-fourths inch in diameter and one and one-half inches long, attached inside the posterior lip of the cervix. The polyp was grasped by its pedicle with a forceps, twisted off, and the base cauterized. She has been examined several times during the two years since the polyp was removed. There is no tumor or enlargement in her pelvis now, and the polyp has not recurred. Her menstrual periods continue to be normal. The abdominal distress ceased immediately after the polyp was removed.

The next time you see your doctor, feel sorry for him. He is the most neglected of all citizens, though no one will deny that he is the most valuable.

He is expected to be first in the aid and comfort of the people in time of epidemic and disaster and first in caring for the sick and hurt at all times, regardless of compensation. He must be the first to answer the call of his government to war to risk his life in trying to salvage the wrecks of battle.

And in return the Government does nothing for him from an economic standpoint. The doctor is denied the benefits of Social Security and similar protections which the Government provides for most of its citizens. No regulations on wages and hours or working conditions apply to him. No provision is made for his future. The doctor is the stepchild of our national family as far as the Government is concerned.

He does not have the safeguards with which the members of nearly all other professions surround themselves. He has no union, no other organization designed for anything more than the exchange of scientific ideas, no association for mutual benefits of a material nature. If you asked a doctor why his profession does not form a sort of guild and join the C.I.O. or the A.F. of L. and take steps to protect the interests of doctors generally, he would be so shaken at the very thought that he would have to write a prescription for his own nerves.

We can just imagine the stir an organization of that nature would create throughout the land. There would be a great outcry, indeed, if the doctors decided they needed a union to better the conditions of their profession, say with reference to hours and compensation and pensions and working conditions in hospitals and elsewhere and to regulate the amount of service they render the public free of charge and to bring about a little more promptness in the settlement of bills among patients able to pay. It would be quite a spectacle to see a committee of distinguished union doctors picketing the premises of some notorious non-payer of medical fees.

But of course you will never see such an organization. The code of the profession requires that the doctor demean himself more rigidly than the rest of us in every way. It requires that he carry on with reference only to the ethics and the dignity of his calling and with no thought of his own welfare. Sill, we think it is an unfair and unreasonable situation when the butcher and the baker are raising prices on the doctor and the Government raising his taxes and he is expected to go along on his old scale. . . —Damon Runyon, in *New York Daily Mirror*.

President's Page

COMMITTEE WORK

To the Members of the Kansas Medical Society:

The committee chairmen have been selected and have accepted the responsibilities of their appointments. All committees have been appointed in full. The successful operation of our Society will depend more than ever during the war years upon our committee work. Certain committees may have somewhat lessened activities—other committees will have more. There can be no satisfactory committee work without one or several meetings of the committees.

Of the chairmen, I would ask that you immediately study the field of your committee work for the year and lay the ground work for it. Early meetings of the committees are especially desirable this year, and all committees should certainly meet by September or October at the latest—some earlier than this.

Of the committee members, I would ask attendance at all committee meetings and the assumption of whatever duties are necessary to carry out a successful committee program.

Three new committees have been appointed this year. The Committee on Plasma has been appointed in recognition of the wide-spread interest in and the rapid extension of the use of plasma in all types of emergencies, both civil and military. It is my hope that this committee can devise some method of making available low-cost dried plasma units to be distributed throughout the State, first supplying defense needs, and then making it available in every community in the State for civilian needs. This problem could be successfully solved if some co-operative arrangement can be worked out with the State Board of Health. Kansas has an opportunity to be one of the leaders in this movement.

The frequency of appendicitis and the still all too many deaths from this disease are well known. It is my hope that the new Committee on Control of Appendicitis may analyze the appendicitis situation in Kansas and lay the ground work for measures especially in the field of lay educational programs that may save lives by bringing patients with abdominal pain to physicians early.

In line with a national movement, the Committee on Conservation of Hearing has been appointed, and should be as successful in this field as our Conservation of Eyesight has been in that field.

There is a real need for an accurate medical history of Kansas. Many physicians in our Society are still with us who have a long acquaintanceship and first-hand knowledge of this history. It is hoped that the Historical Committee may develop and publish this history of Kansas. However, if war conditions make this impossible, it is still highly important that the committee begin at once the collection of historical facts, information and material while first-hand information is still available. This material should be collected and stored in the central office for use as soon as possible.

The committee appointments have been made as carefully as possible to represent fairly all sections of our State, and I hope that each committee member will justify his appointment by active committee work. I am more convinced than ever that we must maintain active committee work in addition to our war responsibilities.

Sincerely,

Henry M. Liker, M. D.

President, The Kansas Medical Society.

EDITORIAL

GRAMICIDIN AND PENICILLIN AS CHEMOTHERAPEUTIC AGENTS

Keefer reports clinical studies of gramicidin¹ and his results indicate (that) another chemotherapeutic agent useful for local therapy. Two substances have been separated from *Bacillus subtilis*, the common soil organisms, gramicidin which is bactericidal for all gram negative organisms, and tyrocidin which is effective against both gram positive and negative bacteria.

Both substances are toxic, producing necrosis of the liver and kidneys and hemolysis of red blood cells when administered subcutaneously or intravenously, they are inactive when given by mouth, but are non-toxic when put in closed cavities or used as topical application. Chronic ulcers, mastoiditis and small, chronic empyema cavities, especially those caused by the hemolytic streptococci were successfully treated.

Dawson² has produced similar results with penicillin, in infections due to gram positive organisms. Penicillin is derived from cultures of the fungus *penicillium*, it is non toxic, it is destroyed by acids and therefore cannot be given by the oral route, has produced successful results in cases of staphylococcus sepsis, pneumococcus endocarditis and hemolytic streptococcus septicemia. *Streptococcus viridans* endocarditis has so far been resistant to penicillin but probably because sufficiently large doses have not been available. Its clinical use is hampered by the small yield. The average daily dosage of 100 to 200 milligrams requires the processing of forty liters of culture broth.

These substances are not at present available for general use but they may represent a new class of chemical agents more important than the sulfonamides.

1. Keefer, Chester S. Lecture at 1942 Session, American College of Physicians.

2. Dawson, M. Henry. Lecture at 1942 Session, American College of Physicians.

REGISTRATION OF DIATHERMY APPARATUS

Announcement was made recently by the Federal Communications Commission of Washington, D. C., that is of great interest to all doctors owning diathermy equipment. The order states that all possessors of apparatus designed, constructed or used for

generating radio frequency energy for therapeutic purposes described generally as diathermy apparatus, must register each such device with the Commission by June 8.

Registration blanks may be secured from the field office of the organization by addressing: the Inspector in Charge, Federal Communications Commission, 809 United States Courthouse, Kansas City, Missouri. The completed forms are then forwarded to the Commission office in Washington, D. C., where if in order and properly filled out the office then issues a non-transferable certificate to the owner, which must be conspicuously affixed to the apparatus. Willful violation of the order is punishable by penalty of \$10,000 or ten years imprisonment or both.

Apparatus that is newly purchased must be registered within fifteen days and notice of apparatus which has been transferred, sold, assigned, leased, lent, stolen, destroyed or otherwise removed from the possession of the original owner must be sent to the Commission not later than five days from date of such transaction.

The order is a war time security measure, under the office of Emergency Management, enacted to give the United States Government knowledge of all persons who possess apparatus equipment for the transmission of radio frequency energy, as diathermy apparatus not only may interfere with radio reception but may easily be converted into short wave radio transmitters and thus might be used to furnish information to the enemy.

All doctors who have apparatus of this kind and who have not already registered them with the Federal Communications Commission should write to the Field office at Kansas City immediately.

PHYSICIANS' CONTRIBUTION TO ORAL HEALTH OF EXPECTANT MOTHERS AND PRESCHOOL CHILDREN

"Parents of a preschool child rarely bring him to the dentist for examination or treatment unless forced to do so because the child has a toothache." This is a common statement made by dentists in discussing the problem of dental care for the preschool child.

"My wife, who is expecting to have her baby in about six weeks, has been unable to sleep or to eat for about a week because of a severe toothache. Is it dangerous to have teeth repaired or removed at this time?" This question is so often asked members of the dental profession that it seems as though every one should know that dental operations can usually

be performed safely during the prenatal period, but that needed dental corrective services should be performed as early in this period as possible.

It is generally known that a child with sore or badly diseased teeth will usually avoid eating protective foods, such as fresh fruits and vegetables, because it hurts his teeth to chew them. He will often tear the crust off the bread before he eats it and will munch soft foods that he can readily swallow, without exerting pressure upon painful teeth. It is quite useless to prescribe an essential diet unless the child's teeth are conditioned to eat it.

The physician, nurse or health official may devise an ideal program relative to diet, rest, exposure to sunshine, exercise and mental attitudes for the expectant mother. We realize, however, if the mother has not been given the instruction to have her teeth examined and conditioned for this period, that the entire program may be disjointed because of pain, sickness or inability to chew necessary foods as a result of deep infection, nerve exposure or other pathosis in her teeth or their supporting tissues.

For various significant reasons, many physicians have been reluctant to instruct the expectant mother relative to the need of early and regular dental care during the prenatal period, or to advise the mother of a preschool child with regard to the need for dental care of the child beginning at the age of two and one-half to three years.

That the status of the physician in these phases of oral health instruction may be clarified, we believe it will be of interest to state the findings of a survey of the opinions of students of problems concerning maternal and child hygiene in the medical and dental professions, recently conducted by the author.

In the forty-eight questionnaires returned, there was almost a unanimity in the opinion that, "The physician, obstetrician and/or nurse, in public health or private practice, should advise the expectant mother relative to dental care as a necessary step in her prenatal health program."

"The physician, pediatrician and/or nurse, in public health and private practice, should advise the mother relative to the need for dental inspection and care of the preschool child beginning at the age of two and one-half or three years as an essential step in promoting maximum nutrition, growth and development."

To instruct in matters pertaining to the care of the prenatal case and the health program for the child during its growth period is primarily the responsibility of the physician. The physician and nurse are usually the first and only ones having the authority to instruct in matters of health, who make contacts

with the mother of a preschool child or the expectant mother before emergency dental care is necessary.

Viewing the problem in this light, it would seem that instructions by the physicians and nurses to mothers and expectant mothers synchronized with efforts toward lay education promoted by the dental profession and health officials, should do a great deal toward preventing the sequelae of uncontrolled oral pathosis as related to the health of the expectant mother and preschool child.—Leon R. Kramer, D.D.S., Director of Dental Division, Kansas State Board of Health, Topeka, Kansas.

THE PREVENTION OF BLINDNESS FROM GLAUCOMA

In order to prevent glaucoma we must first have a proper conception of what the term means. To many persons, including physicians, glaucoma is thought of as an eye disease in which the globe becomes harder than normal. No better definition of the word can be found than that given by Duke-Elder in his recent text book, namely, "The term glaucoma does not connote a disease entity, but embraces a composite congeries of pathological conditions which have the common feature that their clinical manifestations are to a greater or lesser extent dominated by an increase in the intra-ocular pressure and its consequences." This definition properly implies that in the attempt to prevent blindness from glaucoma we must study the affected patient from the standpoint of his general condition, correcting faulty function as far as possible, eliminating bad habits of living, removing foci of infection and correcting disturbances of endocrine balance.

Increasing familiarity with the term glaucoma by the laity is a most favorable sign, for when the patient remarks to his physician, "I hope I haven't got glaucoma," the examiner is not likely to overlook at least its possibility. If the family physician will keep in mind that chronic, simple glaucoma is not uncommon in people in middle life and thereafter, and will remember that dilated pupils and an eye that feels hard to palpation probably mean glaucoma, he can direct his patients earlier to the ophthalmologist.

By far the most prevalent type of increased intra-ocular pressure is that known as chronic, simple glaucoma, because it develops insidiously and causes no pronounced symptoms, at least until late in the course. It is here that we can hope most for improvement and relief by early recognition of the disease, careful study of the patient as a whole and prompt treatment, either medical or surgical. Congenital or

juvenile glaucoma depend upon structural defects in the eye and do not respond well to treatment. Secondary glaucoma, that which results from other pathological states in the eye, such as iritis, dislocated lens, hemorrhage into the anterior chamber or vitreous and many other conditions, demand treatment of the underlying cause and also the hypertension which has ensued.

Acute congestive glaucoma is really a vascular crisis, due to loss of control of the blood vessel walls, especially in the iris, ciliary body and choroid, coming on so rapidly that the eye has had no opportunity to become compensated. The intense pain, nausea and vomiting, dilated pupil and steamy cornea are sometimes mistaken for iritis, and atropine is instilled into the eye, further augmenting the pressure by increasing the size of the pupil. Simply palpating such an eye is sufficient to differentiate between the two conditions, since the glaucomatous eye feels stony hard and that of iritis is usually normal.

The question of when to operate in glaucoma is a difficult one to answer. Some ophthalmic surgeons consider that glaucoma is always a surgical problem and thereby are saved much worry in making a decision as to when to operate, but since the most ardent proponents of surgery can claim for it nothing more than a reduction of pressure, many ophthalmologists prefer to use miotics and pressure reducing drugs so long as the pressure can be kept within normal limits. Frequent checking of the patient's vision, recording the tension by use of the tonometer, and above all, careful study of the visual fields are essential to the proper management of every glaucoma case. The patient must be made to understand that he has a serious condition requiring careful observation and treatment by the ophthalmologist and conscientious cooperation on his own part.

It is fallacious to look forward to a day when some miracle drug, such as the sulphonamide group, will be discovered, whose use will prevent or cure glaucoma, especially the more common type of glaucoma simplex. Bio-chemistry will probably direct us eventually to a better understanding of the perverted physiology which sets in motion the causes of increased intra-ocular pressure and so aid in the prevention and treatment of this, the most baffling and important disease complex in ophthalmology. Until then our hope lies in early recognition of the glaucomatous changes, careful study and treatment of the patient and not just his eyes, and proper medical and surgical care. More widespread information concerning glaucoma is certain to arouse greater interest in the study and treatment of the disease itself. The prevention of blindness has assumed added importance with the acceleration of the war industry

program. Dr. Eugene M. Blake, secretary-treasurer of the American Ophthalmological Society and clinical professor of ophthalmology at Yale School of Medicine, contributes the above editorial comment at the invitation of the Journal—From the Connecticut State Medical Journal.

BACTERIAL WARFARE

During World War I there was talk of the methodical and diabolical spread of disease germs as an instrument of warfare by the enemy. During the years that have passed since that time such discussions are to be found chiefly in the fiction which has war as its background. Recently, if we are to believe the charge brought by Dr. P. Z. King, Director of the Chinese National Health Administration, the Japanese are actually engaged in bacteriological warfare against the Chinese. Dr. King cites chapter and verse in a plea for drugs of the sulfonamide group and for rat poison with which to combat epidemics now in process.

We are told that five well authenticated examples of attempt to spread disease among civilians in China are now on record. The tale of horror begins in Ningpo where on a certain day in October, 1940, a low-flying Japanese plane spread wheat grains over the city. A few days later an epidemic of bubonic plague broke out claiming ninety-nine victims. About the same time another plane spread wheat and rice grains mixed with fleas over Chuhsien and again bubonic plague was the sequel. A few days later three planes appeared over Kihwa, dropping many large granules which on microscopic examination showed numerous gram-negative bacilli, morphologically identical with *P. pestis*. Some months later another plane scattered over Changteh rice and wheat grains and other particules upon which organisms resembling *P. pestis* were also identified. A week later cases of plague began to appear. An examination of 200 rats caught in Changteh at the beginning of the epidemic showed no signs of plague, but a month later many rats exhibited definite indications of infection. The final example cited is that of an epidemic of serious proportions occurring in three Chinese provinces after "a large number of sick rodents had been set free by the enemy in the epidemic area."

"The enumeration of facts thus far collected" writes Dr. King, "leads to the conclusion that the Japanese army has attempted bacterial warfare in China. Fortunately, the mode of infection and the method of control of plague are known. Our difficulty at present is the shortage of the anti-epidemic supplies required. New drugs, more or less effective

for treatment of plague cases, sulfathiazole and allied sulfonamide compounds, China cannot as yet produce herself."—From *The Virginia Medical Monthly*.

TUBERCULOSIS CONTROL

TUBERCULOSIS IN INDUSTRY

The prevalence of tuberculosis in any community is determined by the general standard of living and by the number of open carriers. In particular occupations the factors of selective employment and unfavorable environment modify the picture. If such factors, work involving silica, for example, are dominant, the incidence in the wage earners will be different from that of their families.

The source of the great bulk of infections is a human carrier with a pulmonary cavity. While the home is probably the place of most childhood and some adult contacts, many primary infections and more reinfections must occur in the place of work. Nurses, physicians and attendants on the sick encounter a real occupational hazard from infection itself and this hazard should be accepted as incidental to the professional life while hospital management should assume the obligation of minimizing opportunities for mass infection.

About sixty-five per cent more young women than men die of tuberculosis between the ages of fifteen and twenty-five. From a practical standpoint the employer of large numbers of women needs an effective medical department if he would avoid a tuberculosis problem. Race is a factor to be considered but it is so intricately associated with the effects of living standards and environment that its effects cannot be weighed. Nutrition is another important factor but also one of the most difficult to evaluate. The influence of fatigue has been studied in the automobile industry and in a steel mill and in neither case was there evidence to suggest that this factor was responsible for any excess of tuberculosis. The belief that abnormal degrees of temperature and humidity lower resistance has little to support it. Trauma does not initiate a primary infection of the lungs.

Tuberculosis has been regarded as the great enemy of the printer (printers and painters have about sixteen per cent more tuberculosis than all occupied males) and in turn was attributed to lead poisoning which printers might have contracted. Certain studies indicate that neither lead absorption nor lead intoxication is the cause of excess tuberculosis among lead and zinc workers.

Fumes and gases are inhalable and many of them are sufficiently irritating to provoke severe inflammatory reaction. Mature judgment on the effects of gas used by the armies during the last war reversed the early opinion that this agent was responsible for the excess of tuberculosis that developed. Routine annual examination of a large group of employees engaged in the manufacture of chlorine, phosgene, hydrofluoric acid and other irritating gases, supports the view that exposure to irritant gases is not responsible for excess tuberculosis.

The general thesis that inflammation of the lungs is necessarily unfavorable to the course of associated tuberculosis has little support. It is probably true that certain kinds of inflammatory reactions may have some influence. The increased incidence of tuberculosis that followed epidemic influenza may have been due in part to pneumonic complications.

In grain handlers exposed to high concentrations of organic dust in unloading lake steamers, 2.5 per cent of a group of 234 showed x-ray evidence of clinically significant tuberculosis and another 2.3 per cent had old healed lesions. Social-economic factors rather than grain dust were thought to be responsible. Tobacco dust has been under suspicion as a cause of tuberculosis since Ramazzini's time in 1700. Yet, in a modern cigar factory with a well organized medical service and air conditioned rooms there was less tuberculosis than in the city where the plant was located. Metropolitan mortality figures for 1937-39 show an index for tuberculosis of 107 in cigar and tobacco factory operatives but it should be noted that seventy-five per cent of the labor, which now produces only twenty-five per cent of the product still works in small shops without health supervision.

Low rates for tuberculosis were found in the Saranac Laboratory studies of the cement and gypsum industries. The usual amount of healed infection was disclosed, so that opportunities for infections had not been lacking.

All these observations support the view that exposure to organic and nonsiliceous dusts has little influence on susceptibility to tuberculosis. Reports on foundries, quartz mining and the granite industry brought out that higher tuberculosis rates prevail in these trades, that there is a greater tendency for such infection to develop after the age of forty rather than earlier and that the infection is extremely chronic, often giving no symptoms of intoxication or a positive sputum until shortly before death. In miners the incidence becomes higher and the prognosis of associated tuberculosis worse as the silicotic reaction increases. Miners exposed to silica dust with no roentgenographic evidence of reaction showed little more tuberculosis than the community in which they lived.

Foundries seem to be responsible for the least amount of tuberculosis, while the granite industry showed that it probably caused the most.

Vermont marble workers had two and one-half times as much tuberculosis as the general population of the state (largely rural) exclusive of the granite center in Barre. By contrast, the rate for granite workers was 130 times the general one.

The value of a good industrial hygiene program was brought out by the experience of the Eastman Kodak plant. This program costs \$10,500 annually, but it also costs \$3,218 to treat one minimal case of tuberculosis. The attack rate in this plant has fallen from 2.3 at the outset of a study to 0.2 at the present time.

The complexities of compensation insurance carriers were discussed. One plan proposed was that evidence of tuberculosis in any form should preclude employment in industries with silica or other proved hazards and that compensation should be allowed for all tuberculosis subsequently developing in such employment. In other industries, with no specific hazards, persons with healed tuberculosis should be permitted to work but no compensation should be allowed for infections that might become active or develop during employment. In view of the evidence that old tuberculosis so rarely breaks down in any industry except industries with silica hazards, this would appear most equitable.

In the summary it was pointed out that, aside from nutrition and social-economic factors, silica is the only other one which has a recognized effect on susceptibility to tuberculosis. Many industrial conditions popularly accepted as predisposing to this disease are without measurable effect.—From *Tuberculosis Abstract*, July, 1942, A Symposium on Tuberculosis in Industry Held at the Saranac Laboratory, Saranac Lake, New York, in June 1941: A Resume. *Journal of Amer. Med. Assn.*, Feb. 21, 1942. "Tuberculosis in Industry," a paper-bound volume of 374 pages, with fifty charts and illustrations, is a complete symposium contributed by twenty-eight industrial hygienists at Saranac Lake, June, 1941. It may be obtained from any local or state tuberculosis association or the National Tuberculosis Association, 1790 Broadway, New York, N. Y. Price on request.

What is the age at which the greatest number of deaths occur? In the United States, as constituted today, more persons die at age seventy-one than at any other age, except in the first year of life. In 1939—the latest year for which we have data available—there were 108,846 deaths of infants under one year of age and about 30,000 deaths of persons at age seventy-one.—*Statistical Bulletin*, Metropolitan Life Insurance Company.

NEWS NOTES

PROCUREMENT AND ASSIGNMENT

Excellent response is being received from Kansas physicians in regard to the Procurement and Assignment program. Approximately 250 doctors of medicine from this State are now serving in the military forces and it is estimated that approximately one hundred additional medical corps commissions are now in process.

The Kansas Medical Officer Recruiting Board which is located at 215-17 Federal Building in Topeka, and which has authority to grant Army medical corps commissions to physicians, recently added an Army Air force physician and a representative of the Army Dental Corps to its staff. The Board is, therefore, equipped to grant commissions in all branches of the Army Medical service.

The Army still has need for many thousands of physicians under forty-six years of age and it is said that the Navy has urgent present need for approximately 3000 physicians in the younger age group. The government, therefore, particularly desires to have physicians under forty-six years of age who can pass the require physical examination and who can be spared from their communities, to apply for commissions immediately.

The Kansas Procurement and Assignment Service Committee recently requested that older physicians who can be spared from their communities and who are willing to volunteer for civilian and industrial medical work, to file their names with the Committee. A considerable number have already done so.

COMMITTEE PROGRAMS

Dr. Henry N. Tihen, President, has prepared the following suggested programs for the Society committees to consider for study and execution during the next year.

The programs are intended merely as suggestions and thus any committee is privileged to delete or add any project desired.

The programs were forwarded recently to the chairman of the respective Society committees.

COMMITTEE ON AUTOMOBILE ACCIDENTS AND FRACTURES

1. The provision of liaison assistance to the Kansas Safety Council, the Kansas Highway Commission, and the Kansas Highway Patrol in the medical aspects of the prevention of automobile accidents, and in the care of automobile accident victims.

2. Continued study of lien laws, arrangements with insurance companies, the Kansas financial responsibility law, and other means wherein physicians and hospitals can be assisted in receiving compensation for the care of automobile accident victims.

3. Continued study of physical examination requirements for the issuance of drivers' licenses.

4. Continued study of tests to determine alcoholic intoxication.

5. Investigation of possibilities for obtaining specially designated automobile licenses for Kansas doctors of medicine.

6. Liaison assistance to agencies interested in fracture

control, and further development of an extensive Kansas program on that subject.

COMMITTEE ON AUXILIARY

1. Assistance to the Auxiliary in obtaining new members and in organizing new chapters.
2. Assistance in placing Hygeia in the offices of Kansas physicians.
3. Assistance in placing Hygeia in all the secondary school of the State.
4. Assistance to the Auxiliary in the placement of books on public health and medicine in the school and public libraries.
5. Assistance to the Auxiliary in presenting exhibits on medicine and public health at fairs, conventions, and similar gatherings.
6. Assistance to the Auxiliary in the presentation of lay educational programs at meetings of women's clubs and similar organizations.
7. Assistance to the Auxiliary in maintaining close liaison relations with the Kansas Women's Field Army for Control of Cancer. Completion of arrangements wherein the Auxiliary will be provided membership on the Executive Committee of the Kansas Women's Field Army.

COMMITTEE ON CHILD WELFARE

1. Assistance to the Kansas State Board of Health in the preparation and execution of its Child Welfare program. Discussion of the projects included in the 1942-43 division of the Child Welfare budget and the provision of suggestions thereon.
2. Continued study of Kansas quarantine regulations and procedure.
3. Assistance to the Kansas Legislative Research Council, the Kansas State Department of Education and the Kansas State Teachers' Association in the preparation of a more efficient and complete school health program for this State.
4. Liaison assistance to the Kansas Committee on Nutrition.
5. Study of tetanus toxoid immunization, and if deemed desirable, the issuance of a bulletin on this subject to the county medical societies.
6. Continued study of child morbidity and mortality in Kansas and of ways in which further reductions can be obtained.
7. Assistance in the presentation of Child Welfare exhibits at lay and professional meetings.
8. Assistance in the presentation of post-graduate courses on pediatrics for Kansas physicians.
9. Study of improvement of milk control in this State.
10. Preparation of a lay pamphlet or pamphlets on nutrition, immunization, and other pediatric subjects for distribution through physicians.
11. The provision of lay and professional information on the subject of modification of measles.
12. Study of the Kenney system for treatment of poliomyelitis and of ways in which information on this subject may be brought to the attention of the Kansas profession.

COMMITTEE ON CONSERVATION OF EYESIGHT

1. Continued assistance in the blind program of the Kansas State Board of Social Welfare.
2. Conferences with the Kansas State Department of Education and the Kansas State Teachers Association as to possibilities for instituting a more extensive conservation of eyesight program in Kansas schools.

3. Development of additional lay educational programs on conservation of eyesight. Consideration of the possibility of preparing a special program of this kind for Kansas industry.

4. Investigation of plans and sources through which eye glasses may be more easily furnished to indigent persons.

COMMITTEE ON CONSERVATION OF HEARING

1. Study of conservation of hearing programs in other states.
2. The establishment of liaison relations with lay organizations interested in this field.
3. Study of school and educational needs in the State of Kansas for the provision of assistance to the hard of hearing.
4. Assembling of information on hearing aids and of the advantages and disadvantages of particular types of equipment available for that purpose.
5. Study of ways and means wherein hearing aid equipment may be more easily provided for indigent persons.
6. The provision of post-graduate programs on conservation of hearing for Kansas physicians.
7. Presentation of exhibits on conservation of hearing at Society State meetings and at lay meetings.
8. Study of the causes of deafness in this State.
9. Study of legislative needs in Kansas for conservation of hearing.

COMMITTEE ON CONTROL OF APPENDICITIS

1. Study of appendicitis control programs in other states.
2. The provision of lay educational information on appendicitis control through sources such as the following:
 - a. Radio and newspapers.
 - b. Pamphlets.
 - c. Kansas State Board of Health.
 - d. Informational labels furnished by pharmacists.
3. Assistance in the provision of post-graduate information on appendicitis control for Kansas physicians.
4. Study of Kansas mortality statistics on appendicitis and of ways in which further reductions can be obtained.
5. The encouragement of hospital staffs to analyze their records in regard to appendicitis mortality and in instituting local programs for reduction of present mortality.
6. The presentation of exhibits on appendicitis control at State Society annual sessions and at lay meetings.

COMMITTEE ON CONTROL OF CANCER

1. Further study of the need for additional cancer therapy equipment in Kansas, and the issuance of a bulletin on this subject to the county medical societies, if additional equipment is deemed to be needed.
2. Decision as to whether a postgraduate course on cancer shall be presented during 1942-43 and if so, preparation of plans in that regard.
3. Continued liaison assistance to the Kansas Women's Field Army.
4. Assistance in the provision of cancer exhibits at lay and professional meetings.
5. Consideration of the possibility of establishing a department in the Kansas State Board of Health to assist in the handling of cancer control programs.
6. Continued assistance in the provision of State-wide lay educational information on cancer.
7. Preparation of a lay pamphlet on cancer for use by the Women's Field Army and other agencies.
8. Continued assistance to the Kansas State Board of Health in the issuance of desk cards to physicians containing cancer control information.

COMMITTEE ON CONTROL OF TUBERCULOSIS

1. Assistance in a liaison capacity with the Kansas Tuberculosis and Health Association, the Division of Tuberculosis of the Kansas State Board of Health, and the Norton Sanatorium.
2. Assistance to the Tuberculosis Committee of the Kansas Legislative Research Council in its studies of tuberculosis in Southeast Kansas, and in the need the State has for a larger number of beds to treat tubercular patients.
3. Continued study of the present statute governing the admittance of patients to Norton Sanatorium, and preparation of a report on this subject for the Tuberculosis Committee of the Kansas Legislative Research Council.
4. Assistance in the Kansas State Board of Health tuberculin testing program.
5. Further extension of Kansas pneumothorax facilities and of county medical society tuberculosis diagnostic clinics.
6. Presentation of a post-graduate course or other post-graduate activities on tuberculosis.
7. Study of the needs in regard to tuberculosis facilities at the University of Kansas School of Medicine.
8. Study of the tuberculosis problem in connection with the Kansas Selective Service program.

COMMITTEE ON CONSTITUTION AND RULES

1. Consideration of any changes needed in the Society Constitution and By-Laws for presentation to the 1943 session of the House of Delegates.
2. Particular study of the following matters in that regard:
 - a. Whether the First Vice President of the Society should be a member of the Council?
 - b. Whether a section pertaining to House of Delegates reference committees, their appointments, and work should be added?
 - c. Whether a section pertaining to associate membership in county medical societies should be added?
 - d. Whether the present Society Defense Program should be changed?

COMMITTEE ON ENDOWMENT

1. Further conferences with the University of Kansas Endowment Association in the interest of obtaining endowment funds for medical research.
2. Investigation of other possibilities for obtaining endowment for medical research.

COMMITTEE ON HISTORY

1. Consideration of the possibility of preparing and publishing a Kansas medical history.
2. The establishment of an archive of Kansas medical history material.
3. Consideration of the possibility of the Kansas State Historical Society presenting a display of Kansas medical history material in its museum.
4. Assistance to the Kansas State Historical Society in obtaining copies of all current medical history material.
5. Preparation of the annual report of the Committee.

COMMITTEE ON HOSPITAL SURVEY

1. Liaison assistance to the Kansas State Hospital Association.
2. Consultation with the Kansas Hospital Association in the institution and operation of its group hospitalization program.
3. Publication of the committee survey of Kansas hospitals to the county medical societies, in order to determine

whether any corrections or additions should be made therein.

4. Study as to whether there are any areas in the State which are not adequately served by existing hospitals, and if so, preparation of recommendations in that regard. Consideration also, as to whether the areas of the State in which national defense projects are being constructed have sufficient hospital facilities to care for the population increases which will result therefrom.

5. Completion of a survey to determine the adequacy of present equipment and facilities in Kansas hospitals and preparation of recommendations concerning any needed equipment.

COMMITTEE ON INDUSTRIAL MEDICINE

1. Cooperation with the American Medical Association Bureau of Industrial Medicine in supplying the needs of this State on this subject.
2. Assistance in a liaison relation with the Kansas Workmen's Compensation Commission.

COMMITTEE ON LEGAL MEDICINE

1. Service in a liaison relationship with the Kansas State Bar Association.
2. Assistance in the development and furthering of programs of mutual interest and assistance to the Bar Association and the Society.
3. Further study of possibilities for improvement of the Kansas coroner law.
4. Further study of ways and means for improvement of medical testimony.

COMMITTEE ON MATERNAL WELFARE

1. Assistance to the Kansas State Board of Health in the preparation and operation of its maternal welfare program. Discussion of the projects included in the 1942-43 budget of the Division on Maternal Welfare, and suggestions thereon.
2. Consideration of post-graduate programs on maternal welfare.
3. Continued study of Kansas maternal morbidity and mortality statistics, and development of further programs for their reduction. Re-issuance of the obstetrical suggestions adopted by the committee.
4. Development of a more extensive lay educational program on maternal welfare.
5. Preparation of a lay pamphlet on pre-natal care for distribution by physicians.
6. Assistance in the presentation of exhibits on maternal welfare at lay and professional meetings.
7. Preparation of a desk card for physicians on pre-natal and obstetrical care.
8. Provision of liaison assistance to the Kansas Obstetrical and Gynecological Society.

COMMITTEE ON LOCATIONS AND MEDICAL DISTRIBUTION

1. Preparation of a study including information and comments on the following subjects:
 - a. The ratio of physicians to population in each of the counties.
 - b. The comparative ratio of physicians to population in the State as compared with other states of similar size and circumstances.
 - c. The percentages of physicians in each county in the young, middle, and old age groups.
 - d. The need, if any, for additional specialists in the State.
 - e. Additional data wherein the Kansas location problem may be more accurately appraised.

2. Completion of arrangements wherein pharmaceutical and surgical salesmen will report available locations and the names of physicians seeking locations to this committee.

3. Study of the possibility of filling a considerable number of vacancies through the redistribution of certain physicians presently located in the State.

4. Consideration of possibilities for arranging with physicians in neighboring communities to provide part-time service in communities where medical facilities do not exist and permanent physicians cannot be readily supplied.

5. Study as to whether any additional physicians will be needed in areas of the State in which national defense industries are being constructed.

6. Other assistance in filling Kansas location needs.

COMMITTEE ON MEDICAL ECONOMICS

1. Continued study of the Kansas indigent medical care problem, and further cooperation with the Kansas State Board of Social Welfare on that subject.

2. Study of pre-payment medical service plans.

3. Study of plans offered by insurance companies for provision of medical service.

4. Conferences with farm groups for discussion of farm medical problems.

5. Conferences with labor groups for discussion of labor medical problems.

6. Issuance of a bulletin to the county medical societies stressing the need for each county society to have a medical economics committee, and for such committees to be active in the study of local economics problems.

7. Continued study of the Athletic Accident Benefit Plan of the Kansas State High School Activities Association.

8. Continued supervision of the Medical Economics Section in the Journal.

9. Study of annuity and similar insurance programs for physicians.

COMMITTEE ON MEDICAL SCHOOLS

1. Continued liaison assistance to the University of Kansas School of Medicine.

2. Continued study of the patient admittance problem in the University of Kansas Hospitals.

3. Assistance in regard to the problem of providing adequate teaching material at the Medical School.

4. Assistance in the handling of the problems which the Medical School will experience by reason of the war.

5. Consideration of the possibility of medical student reserve officers being permitted to wear uniforms.

6. Study of housing and food conditions for students at the Medical School.

7. Study of ways in which the Kansas profession can more actively assist the Medical School.

COMMITTEE ON NECROLOGY

1. Preparation of the annual report of the committee. Arrangements with the program committee for the 1943 annual session to have a space reserved on the general assembly program, following the President's address, for presentation of the report.

2. Consideration as to whether this report should continue to be presented at general assembly meetings, or be presented to the House of Delegates. If deemed advisable for it to be presented to the House of Delegates, preparation of recommendations for the Society Committee on Constitution and Rules in order that the Society By-Laws may be changed in that regard.

COMMITTEE ON PHARMACY

1. Assistance in a liaison relation with the Kansas State Pharmaceutical Association.

2. Joint action with the Kansas State Pharmaceutical Association in obtaining proper interpretations of the provisions of the Federal Drug Law, and in publishing same to Kansas physicians and pharmacists.

COMMITTEE ON PLASMA

1. Study of various methods for the preparation of plasma.

2. Study of the possibility and practicability of developing a State-wide program wherein plasma may be supplied at a low cost.

3. Preparation of a survey of existing plasma facilities in the State.

4. The provision of information to Kansas physicians on the use of plasma.

5. The presentation of exhibits on plasma use at Society State meetings.

6. Cooperation with civilian defense agencies in regard to plasma needs and uses. Discussion of this subject with Col. W. D. Hunt, Regional Director of Medical Civilian Defense for this area.

COMMITTEE ON PUBLIC HEALTH AND EDUCATION

1. Assistance in a liaison relation to the Division of Public Health Information of the Kansas State Board of Health, and in the development and extension of activities of the following kinds:

a. The presentation of public health exhibits at lay meetings.

b. The establishment of an extensive movie library, through which lay educational and scientific movies may be made available for loan to numerous groups and agencies.

c. The preparation and distribution of pamphlets on public health subjects.

d. The preparation of transcriptions and other facilities for wider use of public health radio programs.

e. Extension of the present news release program.

f. The more frequent use of "spot news" releases on epidemics, unusual public health conditions, new programs, timely and seasonal health information, et cetera.

g. The preparation and distribution of talk outlines on public health topics.

h. The preparation of reports on public health needs in Kansas for legislators, lay groups, et cetera.

i. The preparation of loan packets of lay educational information.

2. The issuance of a bulletin campaign to the county medical societies urging that they develop, encourage, and actively engage in needed public health programs in their communities such as school programs, lay talks, milk control, immunization programs, venereal disease programs, et cetera.

3. Assistance in the provision of lay educational information on nutrition.

COMMITTEE ON SCIENTIFIC WORK

1. Assistance to the Kansas State Board of Health in the publication of special bulletins to Kansas physicians, calling attention to threatened or existing epidemics, unusual increases in morbidity and mortality, public health conditions, et cetera.

2. Study of Kansas post-graduate needs; coordination of Kansas post-graduate programs; development of a larger

number of county, joint county, and district post-graduate courses; consideration of the possibility of recommending a larger number of reasonable fee courses.

3. Assistance in the preparation of the 1943 annual session scientific program.

4. Approval or rejection of applications for commercial exhibit space at the annual session.

5. Study of the needs for additional scientific equipment and facilities in the State, and of the economic use of present equipment and facilities.

6. Publication of bulletins and articles on new developments in medicine and surgery.

7. Study of ways and means wherein morbidity reporting in Kansas may be made more complete and efficient.

8. Study of needs in Kansas for institution of a program or committee activity on geriatrics.

9. Publication of bulletins on the following subjects:

a. The preparation of a larger number of scientific articles, and the presentation of a larger number of scientific exhibits at national and other meetings by Kansas physicians.

b. The assistance available through the library loan service of the American Medical Association.

c. The importance of members attending as many inter-sectional and national post-graduate activities as they can each year.

d. The need for members to cooperate with the Kansas State Board of Health in prompt and efficient reporting of morbidity and mortality.

e. The need for all county medical societies to hold regular and frequent scientific meetings.

COMMITTEE ON STORMONT MEDICAL LIBRARY

1. Consideration as to whether any changes should be made in the present purchase list of Stormont Medical Library.

2. Discussion with the Kansas State Library Committee, concerning plans for obtaining more adequate and satisfactory housing for the Stormont Medical Library.

COMMITTEE ON STUDY OF HEART DISEASE

1. Consideration of future plans for the provision of post-graduate work in this State on heart disease.

2. Assistance in presenting exhibits on heart disease at lay and professional meetings. Consideration of the possibility of presenting an exhibit, describing the Kansas program on this subject, at an early American Medical Association meeting.

3. Preparation of a brochure for Kansas physicians, on heart disease control.

4. Consideration of the possibility of establishing a division in the Kansas State Board of Health for assistance in the handling of heart disease control programs.

5. Further assistance to the Kansas State Board of Health in arranging for the standardized reporting of heart disease morbidity and mortality.

6. Preparation of a lay pamphlet on heart disease for distribution by physicians.

COMMITTEE ON VENEREAL DISEASE

1. Assistance in the handling of the venereal disease problem at Kansas Army cantonments and national defense projects.

2. Study of the venereal disease statistics and information available through the Kansas Selective Service program.

3. Study of the advantages and disadvantages of pre-marital and pre-natal physical examination laws. Publication of a report, possibly through the Kansas Legislative Research Council, on these subjects.

4. Study as to whether Kansas has an adequate amount of dark field diagnostic facilities, and if not, preparation of a program on that subject.

5. Issuance of bulletins to the county medical societies on the following subjects:

a. The need for all venereal disease patients to be treated adequately and scientifically, and at a price they can afford to pay.

b. The need for all county medical societies to discuss the extent of the venereal disease problem in their communities at their meetings, and to present frequent scientific programs thereon.

c. The need for routine Wassermann's to be used on all pregnant women.

d. The need for all physicians to cooperate in the efficient reporting of venereal disease to the Kansas State Board of Health.

COMMITTEE ON WAR WORK

1. Assistance in the handling of the following programs:

a. The Procurement and Assignment Service program.

b. The medical aspects of the Selective Service program.

c. The Civilian Defense program.

d. The provision of medical assistance for civilian, industrial and medical educational needs.

e. Other programs in conjunction with the war effort.

INDIGENT MEDICAL CARE

The Kansas State Board of Social Welfare recently requested that all County Welfare Directors submit descriptions of indigent medical care plans being used in their counties.

After study of all existing plans is completed, the Board plans to assist all counties in developing efficient and extensive plans for this purpose.

KANSAS PSYCHIATRIC MEETING

The Kansas Psychiatric Society held its quarterly meeting in Topeka on July 15. Speakers at the meeting were: Major George Morse of Ft. Riley who discussed "Psychological Testing in the Army"; Major Fred Wechman of Ft. Riley who spoke on "Internal Medicine and Psychiatry in the Army" and Dr. Merton Gill of Topeka, who discussed "Hypertension as a Psychosomatic Approach."

COMMITTEE CHAIRMAN

Dr. Henry N. Tihen, President, recently announced the appointment of Dr. J. L. Latimore of Topeka, as Chairman of the Society Committee on Legal Medicine for the year 1942-1943 to succeed Dr. Earl Mills of Wichita who is entering military service.

INSURANCE FOR PHYSICIANS

From a legal standpoint it is probably true all physicians serving in the military forces can be subjected to individual malpractice actions for medical and surgical services rendered in conjunction with military duty.

Where such matters have arisen in the past it has been the custom of the Government to attempt to provide counsel and other defense assistance. Likewise, a defendant medical officer has the right to have any case of this type transferred to a Federal Court of jurisdiction. If however,

a judgment should be rendered against a medical officer there is no legal provision through which the same could be paid by the Government or through which the defendant physician could be reimbursed by the Government.

Although suits of this type have been rare it is probably true that physicians entering the military forces should continue their liability insurance during the period of their service. Likewise, most of the companies writing liability insurance have low cost policies for this purpose.

NEW LICENSEES

The Kansas State Board of Medical Registration and Examination held a meeting in Kansas City on June 2-3, and subsequently announced that certificates to practice medicine and surgery in Kansas were granted to the following eighty-eight doctors:

NAME	ADDRESS
V. Dale Alquist.....	Clay Center
Robert L. Anderson.....	Emporia
Philip J. Antrim.....	Spivey
Umbert E. Anz.....	Kansas City, Missouri
Marvin P. Baecker.....	Lawrence
Volney B. Ballard.....	Kansas City
Paul A. Binter.....	El Dorado
Henry S. Blake, Jr.....	Topeka
James R. Blakeney.....	Kansas City, Missouri
Harvey L. Bogan.....	Kansas City
Vernon L. Branson.....	Osawatomie
Dean K. Brooks.....	Lawrence
Morton E. Brownell, Jr.....	Wichita
Ernest A. Cerv.....	Wichita
Edward R. Christian.....	Rozel
Shirley E. Clark.....	Great Bend
Richard F. Conard.....	Kansas City
Lewis L. Coriell.....	Stanford, Montana
Howard S. Cowley.....	Devil's Lake, North Dakota
John B. Dixon.....	Mound Valley
Galen S. Egbert.....	Dighton
Howard R. Elliott.....	Pittsburg
Frank S. Forman, Jr.....	Kansas City
Thomas R. Frazer.....	Larned
Charles T. Frey.....	Wichita
Robert E. Funk.....	Tulsa, Oklahoma
Merton M. Gill.....	Topeka
Rex A. Gish.....	Kansas City
James D. Gough.....	Chanute
Jack W. Graves.....	Topeka
David E. Gray.....	Topeka
John R. Green.....	Independence, Missouri
William E. Grove.....	Newton
Condon P. Hagan.....	Wichita
Carl W. Hagler.....	Topeka
Lyman L. Harrison, Jr.....	Marysville
Matthew Heller.....	Chanute
Victor H. Hildyard.....	Kansas City
John D. Hilliard.....	Attica
William D. Horton.....	Chanute
Philip H. Hostetter.....	Holton
Otis E. James, Jr.....	Kinsley
Alan R. Jay.....	Wichita
Edgar W. Johnson, Jr.....	Kansas City, Missouri
John H. Lathrop.....	Norton
Marjorie J. LeMay.....	Baldwin
Alfred R. Madson.....	Ottawa
Hubert C. Martin.....	Coffeyville
Gerald L. Miller.....	Kansas City, Missouri

NAME	ADDRESS
William R. Miller.....	Lyons
Robert A. Moore.....	Cleveland, Missouri
Frederick S. Morest.....	Kansas City, Missouri
Vernette A. Mueller, Jr.....	Wichita
John S. Myers.....	Kansas City, Missouri
Frederick J. McCoy.....	McPherson
Richard O. Nelson.....	Lawrence
Waldo L. Newberg.....	McPherson
Philip C. Nohe.....	Kansas City
William E. Nunnery.....	Coffeyville
Harry E. O'Donnell.....	Junction City
James R. O'Neill.....	Kansas City
Carl A. Petterson.....	Kansas City
Edwin L. Pfuetze.....	Kansas City
Elizabeth R. Phillips.....	Wichita
James C. Pinney.....	Kansas City
Robert C. Polson.....	Lawrence
Robert R. Remsberg.....	Lola
Robert E. Riederer.....	Rozell
Norton R. Ritter.....	Baxter Springs
Edgar L. Robinson.....	Lawrence
Joseph H. Rohr.....	Burlington
Abraham L. Saferstein.....	Kansas City, Missouri
George E. Sanders.....	Leavenworth
Robert L. Schwab.....	Hutchinson
Jack V. Sharp.....	Wichita
Robert R. Snook.....	Topeka
Wayland A. Stephenson.....	Lawrence
James N. Sussex.....	Kansas City
David L. Traylor.....	Lebo
Francis O. Trotter, Jr.....	Kansas City, Missouri
Henry P. Wager.....	Leavenworth
James D. Watson.....	Claflin
Edward C. Weiford.....	Kansas City, Missouri
John P. White.....	Parsons
Thaddeus H. White.....	Manhattan
Charles W. Wilson.....	Wichita
Jay K. Wisdom.....	Russell
George W. Wise, Jr.....	Topeka

A special examination will be held in Kansas City, Kansas, at the Chamber of Commerce, 727 Minnesota Avenue, on September 15-16, 1942, for the benefit of the fall graduates of the University of Kansas School of Medicine in order to speed up the medical program in the war emergency.

DEFENSE BULLETIN

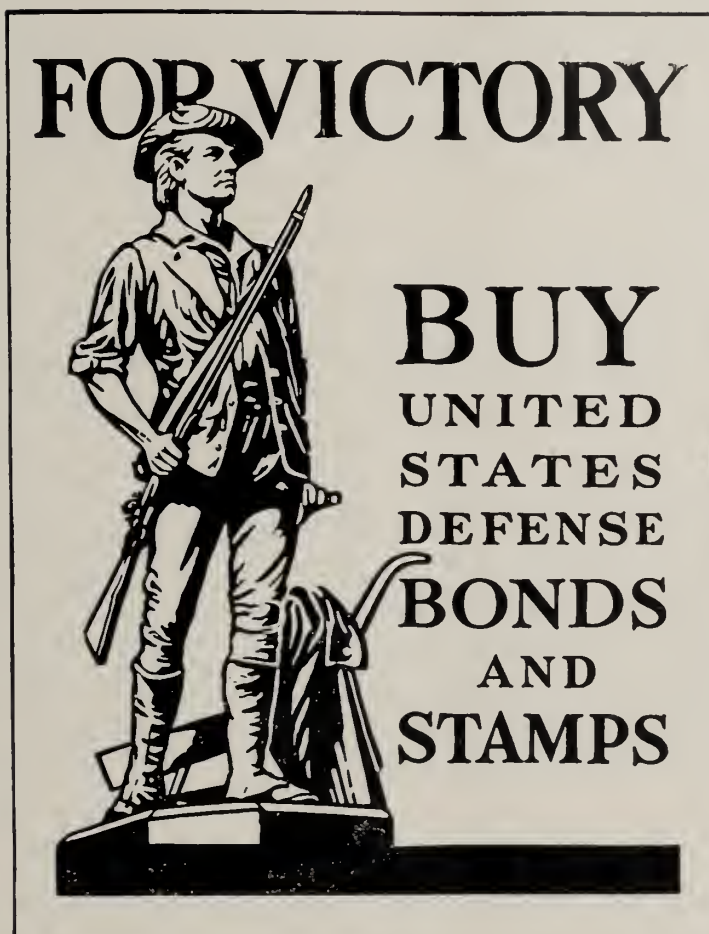
The following bulletin was recently published by the State Council of Defense for Kansas:

"To All Chairmen of County and City

Local Defense Councils:

Governor Payne Ratner, Chairman of the State Council of Defense, has received this splendid report from Major Charles A. Anderson, F. A., Regional Assistant, Protective Services, OCD, Omaha, Nebraska.

"Civilian Defense is going forward by leaps and bounds in Kansas. The people are taking it in a serious-minded way and doing all they can. I feel that with a little more training and work, the people of Kansas could take care of themselves in a very satisfactory way during an emergency. I have found, during my recent trip through Kansas, that the Air Raid Warden Instructor's School held at Lawrence, June 5, 6, and 7, added a very beneficial effect in starting and completing the organization of the United States Citizens Defense Corps in the various cities throughout the



WAR NEEDS MONEY!

*It will cost money to defeat our enemy aggressors.
Your Government calls on you to help now.*

*Buy Defense Bonds or Stamps today. Make every
pay day Bond Day by participating in the Pay-roll Sav-
ings Plan.*

Bonds cost \$18.75 and up. Stamps are 10¢, 25¢ and up.

The help of every individual is needed.

Do your part by buying your share

State. In the cities that do not have a well organized Defense Corps, I find that the officials of the city are very anxious, now, that one be established.

"There is one outstanding condition in Kansas, and that is the well organized Emergency Medical Division in every town that I have visited. It seems that either the Doctors sense the seriousness of the situation, or they have been warned through their State Board of Health or Medical Society. But, the fact remains, it is very noticeable, that the Emergency Medical Division is the most completely organized of any of the other protective services in the Civilian Defense program, within the State."

This office is proud of the above report. Much of the success attained is due to the splendid leadership of Governor Ratner, on a State-wide basis, and to the influential help of those who have taken the lead in their local communities. Yet, the greatest credit goes to the patriotic, intelligent, hardworking people of Kansas as a whole. Folks, like you, serving in your home towns and on the farms, will continue to make the Civilian Defense program succeed in the future.

Sincerely yours, Dale A. Fisher, Executive Assistant."

TOPEKA PSYCHOANALYTIC INSTITUTE APPROVED

According to a notice in the Journal of the American Medical Association for June 13, the American Psychoanalytic Association at its meeting in Boston recently gave approval of the proposed Institute for Psychoanalytic Training at Topeka under the supervision of the Topeka Psychoanalytic Society. This type of training has been carried on for several years under the supervision of the Chicago Institute. Topeka has now been granted independent standing and will carry on its training activities as a recognized institute.

PLASMA COMMITTEE

The following are the minutes of a meeting of the Society Committee on Plasma held in Topeka on July 12:

"A meeting of the Committee on Plasma was held at the Hotel Jayhawk in Topeka on Sunday, July 12th.

Members of the Committee present were: Dr. Warren F. Bernstorff, Chairman, of Winfield; Dr. F. C. Beelman, of Topeka, Dr. John Campbell of Pratt, Dr. Geo. R. Combs of Leavenworth, Dr. John B. Nanninga of Newton, Dr. J. H. O'Connell of Topeka, Dr. Fred G. Schenck of Burlingame and Dr. Geo. I. Thacher of Waterville. Clarence G. Munns was also present.

Dr. Bernstorff commented on the fact that the Society has not previously had a committee on this subject and that Dr. Henry N. Tihen, President, appointed the committee this year with the thought in mind that the field of plasma use is an important and growing one and that the Society and the committee can accomplish much assistance therein.

Dr. Bernstorff also stated that a suggestion had been made concerning the possibility of the Kansas State Board of Health arranging to purchase equipment and to manufacture and distribute dried plasma in order that plasma assistance might widely and easily be made available in this State at low cost and that he had asked Dr. F. C. Beelman, Secretary of the Kansas State Board of Health, to investigate and report upon possibilities in this connection.

Dr. Beelman then presented a report describing the methods and procedure for the processing of dried plasma,

the types of equipment required, the facilities and assistance which would probably be necessary to institute a program of the above kind, and the fact that the cost of the necessary facilities and equipment would approximate \$6000.

Discussion followed as to the possible advantages and disadvantages of the Kansas State Board of Health entering into a program of this kind. The following decisions were then made:

a. That a sub-committee of the Committee, consisting of Dr. Helwig, Dr. Beelman, and Dr. Thacher, should be appointed to study possible methods of preparation and distribution of plasma in this State.

b. That a sub-committee consisting of Dr. Campbell and Dr. Nanninga be appointed to prepare information and reports for the membership on the therapeutic use of plasma.

c. That a sub-committee consisting of Dr. O'Connell be appointed to make a survey of existing plasma facilities in this State.

d. That a sub-committee consisting of Dr. Schenck be appointed to assist in preparing an exhibit on plasma use for presentation at the next Society State meeting and at other similar meetings.

e. That a sub-committee consisting of Dr. Bernstorff and Dr. Combs be appointed to assist the plasma programs of civilian defense agencies in this State.

The sub-committee were asked to prepare information on the respective subjects assigned to them and to report thereon at the next meeting of the committee.

Dr. Bernstorff read the suggested program prepared by Dr. Henry N. Tihen, President, of possible projects which it is believed the committee can accomplish during 1942-43. On a motion made by Dr. Thacher, seconded and carried, the suggested program was accepted as read.

Dr. Beelman offered to obtain booklets from the National Civilian Defense Council in regard to plasma use in conjunction with that program and to forward copies of these booklets to each member of the committee.

Adjournment followed."

NATIONAL PHYSICIANS COMMITTEE

The National Physicians Committee recently published the following announcement in regard to the approval of its program by the American Medical Association:

"On June 9th, in Atlantic City, the House of Delegates of the American Medical Association adopted two resolutions of vital importance to National Physicians Committee operations. Resolution No. 1 reads:

"BE IT RESOLVED; that we register our approval of the activities of the National Physicians' Committee for the Extension of Medical Service, commend the Board of Trustees and the Management of this institution for the efforts they have made to enlighten the general public in connection with American Medicine's methods, progress and achievements and in pointing out that the public has a vital interest in the final result; and,

BE IT FURTHER RESOLVED that it be declared the policy of this House of Delegates to encourage this effort and similar efforts with identical purposes.

Resolution No. 2 reads:

BE IT RESOLVED that we, the House of Delegates of the American Medical Association, place ourselves officially on record as recognizing our responsibility for making the utmost effort to preserve the elements of independence and freedom of action that will make possible the easy re-entry of physicians to civilian practice. To this end we recom-

A NEW BUSINESS CODE FOR KANSAS

AFTER thorough study by the Kansas Legislative Council and its research department, the Kansas Legislature at its 1939 session passed a revised General Corporation Code, effective June 30, 1939, which has been widely hailed as a progressive step in the state's relationship with corporate bodies.

In a brief analyzing the Code, Mr. Al F. Williams, general counsel for the Associated Industries of Kansas, declares that "Kansas can no longer be referred to as a state that harasses, annoys and embarrasses corporations." He adds:

"No changes have been made in the old law that will curb or restrict the activities and business of corporations that desire to transact a legal and lawful business in Kansas, but an attempt has truly been made to open a door to corporation activities, remove useless restrictions and unwarranted interference with corporate business and permit those who desire to operate as corporations to transact their business in their own way so long as they are honest, and presents, undoubtedly, a most heartening example of the change of the public attitude toward corporations in this state."

It should be remembered by corporations desiring to locate in Kansas that this state exacts no franchise tax, but simply a state income tax of two per cent flat upon net income of corporations. There are no general or special levies or assessments that are not likewise directed against individuals.

The Kansas Workmen's Compensation Law provides reasonable but adequate benefits and is uniformly administered in an equitable manner.

Further information regarding the Code and its application will be provided upon request.

KANSAS INDUSTRIAL DEVELOPMENT COMMISSION

801 HARRISON

TOPEKA, KANSAS

mend that a definite part of each program of every component member Medical Society be devoted to a reconsideration of the traditions, the standards, the freedoms, the effects of the absence of restraints and outside controls which have contributed so materially to American Medicine's unequalled progress and vast achievements.

The first of these resolutions is an acknowledgment of the effectiveness in action and the importance of the activities of National Physicians Committee. The second resolution represents a recognition of the necessity for devoting time, study and research to those aspects of medical practice in the United States not directly connected with scientific advancement and technical effectiveness."

GROUP HOSPITALIZATION

The Kansas Blue Cross Group Hospitalization plan instituted operation on July 1 with 531 subscribers, according to Mr. Sam J. Barham, Executive Director of the Kansas Hospital Service Association, Inc. The headquarters office of the program has been established in the Crawford Building in Topeka.

Owing to the fact that most of the initial work in getting the plan started was done in Topeka and vicinity, most of the subscribers in the beginning were Topekan. However, the work is now being carried to other sections of the State and meetings have been held in various towns to acquaint employers with the plan, in order that they may explain it to their employees.

The Kansas Hospital Service Association, Inc., is an association of hospitals in the State incorporated by a special legislative act to provide communities with a means of budgeting hospital needs in advance. It is a non-profit organization and no commissions, fees or bonuses are to be paid to anyone.

Any group of employees may subscribe, and self-employed persons enroll through organizations to which they belong, provided all subscribers within a group have the same occupation. Benefits include thirty days of hospital care each year for the subscriber as well as thirty days each year for each member of his family in an accommodation costing up to \$4.00 a day.

The contract which will be issued to subscribers under the plan is as follows:

"I. GENERAL STATEMENT

(a) This subscription agreement between the "subscriber" and the Kansas Hospital Service Association, Inc., a corporation not for profit, herein called the "Service Association," entitles the subscriber and family participants, if any, to receive hospital service following the date of execution of this subscription agreement as herein defined, during the period for which subscription charges have been paid, upon and subject to the terms, conditions, and limitations hereinafter set forth.

(b) This agreement, endorsements, and attached papers, if any, constitute the entire contract between the parties. Neither the Service Association or any of its representatives or employees, is authorized to vary or change any of the terms of this agreement except as hereinafter provided.

(c) No statement by the subscriber in his application for a subscription agreement shall avoid the agreement or be used in any legal proceeding hereunder.

II. DEFINITION OF TERMS

(a) The term "subscriber" shall mean any individual with whom the Service Association enters into a subscription agreement.

(b) The term "participant" shall mean the subscriber, the spouse, and any unmarried child of the subscriber under 19 years of age, dependent on him for maintenance.

(c) The term "family group" shall include only the participants whose names have been listed by the subscriber on the application for a subscription agreement, provided, however, that the subscriber shall have the privilege to add the name of any eligible individual at the beginning of the contract year, except that a newly married spouse or legally adopted child may be added within sixty days after marriage or adoption. A new born infant may be added immediately after birth if the parents have been participants jointly for eight (8) consecutive months, otherwise a new born infant may not be added until discharged from the hospital following birth. Infants born at home, if both parents are participants, may be added immediately.

(d) The term "subscription agreement" is understood to mean the agreement entered into between the Service Association and the subscriber, under and by virtue of which participants become entitled to the benefits of this plan.

(e) The term "effective date" shall mean the date upon which written application is accepted by the Service Association, signified by the issuance of this subscription agreement bearing the date upon which benefits as herein listed become available to participants.

(f) The term "subscriber's agent" shall mean any individual who, or firm, association, or corporation which, has agreed to collect the charges payable under this agreement and to pay the same to the Service Association. Such subscriber's agent shall be construed to mean the agent of the Service Association.

(g) The "duration of each subscription agreement" shall be the period for which subscription charges have been paid.

(h) The term "member hospital" shall mean any hospital with which the Service Association has a contract for the rendering of hospital service covered by this subscription agreement.

III. EXTENT AND DURATION OF HOSPITAL SERVICE

(a) Each subscriber and each family participant shall be entitled during any contract year under this agreement to hospital service for a total period of thirty (30) days except as limited under IV, (c).

(b) In computing the number of days of hospital service, either the day of admission or the day of discharge shall be counted, but not both.

(c) No benefits shall be available or due a participant under this subscription agreement after such participant has been advised by his attending physician or surgeon that further hospital service is not required.

IV. BENEFITS

(a) In Member Hospitals:

1. Bed and board in accommodations for which the regular hospital rate shall not exceed \$4.00 per day; if the participant occupies an accommodation for which the regular hospital rate exceeds \$4.00 per day, the participant shall pay to the hospital the difference between that amount and the rate of the accommodation occupied.

2. Special diets.

3. General nursing service.

4. Routine laboratory examinations.

5. Routine medications, drugs and dressings.

6. Operating room service.

7. Delivery room service (See Section IV, paragraph c).

8. Anesthesia equipment and materials, but not administration thereof.

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9. Nursery care, and all other benefits listed above, to new born infants (See Section II, paragraph c).

(b) In Non-Member Hospitals

In the participant elects to use other than a member hospital, the Service Association, upon receipt of notice and after making such arrangements as are necessary, will either pay any approved hospital for services defined in the subscription agreement or will reimburse the patient upon proof of eligibility for service and presentation of a receipted hospital bill within the limits of this agreement. Such payments, however, shall not exceed the average amounts paid member hospitals for similar services.

(c) Maternity Benefits

Benefits in obstetrical or maternity cases, or for the treatment of accidents or complications of a current pregnancy, shall be available to a participant enrolled as a spouse or subscriber under a family subscription agreement only after eight (8) months of continuous participation by both the husband and wife, and benefits shall be limited to not more than ten days' duration.

V. BENEFITS NOT PROVIDED

Benefits do not include the following:

(a) Services of private physicians, surgeons, or private nurses or their board.

(b) Hospital service for illness or conditions known by the subscriber or family participant to require hospitalization at the time of application for this subscription agreement.

(c) Hospital service for occupational injuries or diseases which is available without cost under Workmen's Compensation laws or laws enacted by any national, state or municipal legislative body.

(d) X-ray service.

VI. CONDITIONS UNDER WHICH HOSPITAL SERVICE WILL BE RENDERED

(a) Hospital service will be rendered to a participant only upon the recommendation of a physician or surgeon who is acceptable for practice in the hospital to which such recommendation is directed.

(b) The participant may select any member hospital and be entitled to benefits as set forth in IV, (a) or any non-member hospital and be entitled to benefits as set forth in IV, (b); however, receipt of such benefits is subject to the rules of the hospital selected by the participant, and includes only the care of illnesses and injuries accepted for treatment by such hospital.

(c) The participant shall present his or her identification card properly signed when applying for hospital service.

(d) Nothing contained in this agreement shall interfere with the ordinary relationship between the participant and any such physician or surgeon selected by the participant.

(e) The subscriber consents that any physician who has made a diagnosis or provided treatment for any condition for which benefits are sought under this agreement, or any hospital in possession of information relating to such condition, may furnish and is authorized to furnish to the Service Association any information relating to such condition, to the extent that it may be lawful.

VII. OVERCROWDED CONDITIONS

(a) If, upon request for admission to a hospital, all beds of such hospital are occupied, the participant agrees to accept accommodations in another hospital.

(b) In the event that, by reason of general epidemic, war, public disaster, or for other reasons, no hospital to

which the participant shall have applied for admission is able to provide hospital service, the responsibility of the Service Association for providing it shall be discharged by the refund to the subscriber of a sum equal to the unexpired portion of any subscription payment beyond the date on which hospital service would otherwise under this agreement have been rendered by a hospital to such participant.

VIII. BENEFITS NOT ASSIGNABLE OR TRANSFERABLE

No person other than the participant, as recorded at the office of the Service Association, is entitled to any benefits under this agreement. It is not transferable, and shall be forfeited if the participant attempts to transfer it or aids or attempts to aid any other person in obtaining benefits under it.

IX. CHANGES IN SUBSCRIPTION CHARGES OR PROVISIONS OF SUBSCRIPTION AGREEMENT

(a) The Board of Directors of the Service Association reserves the right to amend or modify the terms and provisions of the subscription agreement, also to determine the amount of the subscription charges and to change the benefits as it deems necessary, except that on change in the amount of the subscription charges or the benefits under the existing subscription agreement shall be effective until the expiration of the period for which subscription charges have been paid. If there is no default in payment after the subscriber has been notified of such change it is understood that the change in rates or benefits is acceptable to the subscriber.

(b) Any notice given herein shall be sufficient if given by the Service Association to the subscriber either by a notice mailed to his address as it appears on the records of the Service Association or delivered to the subscriber, as the Service Association shall elect.

X. TERMINATION, GRACE PERIOD, RENEWAL AND REINSTATEMENT OF SUBSCRIPTION AGREEMENT

(a) Any subscription agreement may be terminated by the Service Association by giving fifteen (15) days' prior written notice to the subscriber, except that the Service Association may not terminate a subscription agreement if, at the time of such notice of termination, the participant shall have properly applied for hospital care or shall then be receiving hospital care under the terms of the subscription agreement. Any such subscription charge paid in advance of the date of termination of a subscription agreement by the Service Association shall be refunded by the Service Association.

(b) The benefit of this subscription agreement shall cease for any family participant at the expiration of the contract year during which the child either attains the age of nineteen (19) years or becomes married.

(c) This agreement may be continued in force by the payment of additional subscription charges. The subscriber shall have fifteen (15) days after the termination of any payment period in which to tender the renewal subscription charge, during which time the agreement shall remain in full force and effect. If the renewal subscription charge is not received by the Service Association or its duly authorized agent within fifteen (15) days after the termination of any payment period, this agreement shall automatically terminate as of the date the prior payment period ended.

(d) If cancellation of this subscription agreement results from default in payment of subscription rates, the subsequent acceptance of a payment by the Service Association or by one of its duly authorized representatives shall rein-

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state the agreement for all conditions requiring hospitalization which are first manifested more than ten days after the date of such acceptance.

XI. SERVICE ASSOCIATION'S AGREEMENT WITH HOSPITALS

(a) The authority of the Service Association to offer the services of member hospitals in executing this subscription agreement is conferred upon the Service Association under and by virtue of a certain contract known as the "Member Hospital Agreement" copy of which is on file and available for public inspection at the office of the Service Association.

(b) The membership in the Service Association of any member hospital and the agreement between the Service Association and the member hospital for the rendering of hospital service by such member hospital to participants may be terminated by either the Service Association or the member hospital at any time upon thirty days' (30) prior written notice to the other; provided, however, the obligation of said hospital to render hospital service shall not cease to all participants in the plan before such termination, until the end of their contract years.

XXII. LIABILITY OF ASSOCIATION AND MEMBER HOSPITALS

(a) It is expressly understood that the Service Association does not itself undertake to furnish any hospital service, but merely to indemnify hospitals for services to participants to the extent herein before specified. The Service Association shall not in any event be liable for any act or omission of any hospital or such hospital's agent or employee.

(b) None of the member hospitals shall be liable for any act of omission or commission of the Service Association or any of the other member hospitals toward any patient admitted to such hospital by virtue of this agreement.

(c) Nothing herein contained shall confer upon the subscriber any claim, right, action or cause of action, either at law or in equity, against the Service Association for acts of a member hospital, or any other hospital, in which he receives care under this subscription agreement."

COUNTY SOCIETIES

At a meeting of the Butler-Greenwood County Medical Society held in El Dorado on June 12, Dr. A. E. Hiebert of Wichita spoke on "Burns and Skin Traction."

At a recent meeting of the Cowley County Medical Society Dr. Warren Bernstorf of Winfield was elected as President and Dr. F. E. Torrance of Winfield as Secretary to fill the unexpired terms of Dr. Howard Snyder and Dr. Wendell Grosjean who are both in the armed forces.

The Central Kansas Medical Society held a meeting in Russell on June 25. Dr. A. W. McAlester of Kansas City, Missouri, spoke on "Diseases of the Eye" and Dr. J. S. McKnight of Kansas City, Missouri, spoke on "Diseases of the Chest."

At a meeting of the Southeast Kansas Medical Society held in Neodesha on June 25, the speakers were as follows: Dr. J. W. Kelso of Oklahoma City who discussed "Cancer of the Cervix"; Dr. F. L. Loveland of Topeka who spoke on "The Procurement and Assignment Service for Physi-

cians" and Major R. W. VanDeventer and Major H. J. Dixon of Topeka who also discussed "The Procurement and Assignment Program." The next meeting of the organization will be held in Pittsburg in September.

The Golden-Belt Medical Society met in Manhattan on July 9. Speakers were: Dr. Frank A. Krusen of the Mayo Clinic of Rochester, Minnesota, who discussed "Physical Therapy"; Dr. Wallace D. Hunt, Regional Director of the Civilian Medical Defense for the Seventh Corps Area of Omaha, Nebraska, who spoke on "Civilian Defense" and Dr. Henry N. Tihen of Wichita who spoke on matters pertaining to the Procurement and Assignment program and the Society program.

The Wyandotte County Medical Society held a meeting in Kansas City on July 14 at which Dr. F. L. Loveland of Topeka spoke on the "Military Medical Situation in Kansas."

MEMBERS

Dr. Paul E. Belknap of Topeka was recently appointed as a member of the Advisory Committee of the Child Hygiene Division of the Kansas State Board of Health.

Dr. John F. Bowser and Dr. Arthur B. Smith, both of Kansas City, are the co-authors of an article entitled "Spontaneous Pneumomediastinum (Mediastinal Emphysems) With Report of Two Cases in Infants" which was published in the March, 1942, issue of Radiology.

Dr. Thomas DeChairo of Westmoreland has recently opened a small hospital in that town.

Dr. A. P. Fleckenstein formerly of Herndon is now located at Selden.

Dr. W. N. Mundell of Hutchinson has been named as county health officer and county physician for Reno County.

Dr. Charles Rombold and Dr. R. B. Michener both of Wichita were guest speakers before the Garfield County Medical Society at Enid, Oklahoma, on June 9. Dr. Rombold spoke on "Sciatic Pain" and Dr. Michener spoke on "Medical Practice in Africa."

Dr. Ira T. Smith, formerly of Atlanta, has moved to Kansas City, Missouri.

An article entitled "Recognition and Treatment of Curable Diseases of the Heart" by Dr. Maurice Snyder of Salina, which was published in the January issue of the Journal was abstracted in the June issue of Southern Medicine and Surgery.

Dr. C. C. Stillman, who has been living in Emporia, has returned to Morganville where he formerly lived.

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"Early Toxemias in Pregnancy" an article by Dr. Samuel T. Thierstein of Lindsborg which was published in the February, 1942, issue of the Journal was abstracted in the May, 1942, issue of the Ohio State Medical Journal.

Dr. George E. Tooley, formerly of Wichita, is now located at San Francisco, California.

Dr. J. L. Lattimore of Topeka was guest speaker at a meeting of the Pittsburg County Medical Society at McAlester, Oklahoma, on June 22.

Dr. William Menninger of Topeka spoke on "Emotional Reactions to War" at a joint meeting of the Academy of Medicine and the Civilian Defense Council of Columbus, Ohio, on June 15.

The Journal of the American Medical Association for July 11 carried a paragraph abstracting an article by Dr. Robert P. Knight of Topeka published in the May issue of the Bulletin of the Menninger Clinic.

DEATH NOTICES

Dr. Maurice N. Bremen, 84 years of age, of Roxbury, died on May 9. He was born in Amsterdam, Iowa, on

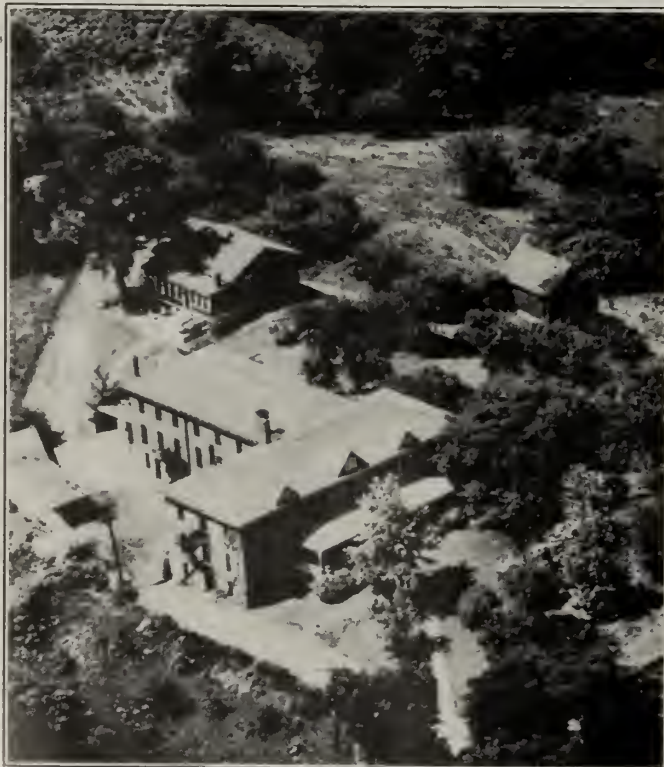
October 26, 1857, and was graduated from the Hahn Medical College of Kansas City in 1900. Dr. Bremen was an Honorary member of the McPherson County Medical Society.

Dr. Charles M. Gibson, 62 years of age, died on June 15 at his home in Pittsburg. Dr. Gibson was born on July 6, 1879, in Richview, Illinois, and was graduated from the University of Kansas School of Medicine in 1907. He was a member of the Crawford County Medical Society.

Dr. George W. Longenecker, 67 years of age, died on June 10 at his home in Elsmore after a long illness. Dr. Longenecker was born near Paola and was graduated from the Kansas City Medical College in 1902. He was a member of the Allen County Medical Society.

Dr. James A. Milligan, 86 years of age, died on April 19 of cancer of the gall bladder, at his home in Garnett. Dr. Milligan was graduated from the Central College of Physicians and Surgeons in Indianapolis, Indiana, in 1883. He was a former member of the Kansas State Legislature and was the author and sponsor of the law which authorized the construction of the Norton Sanitarium. He was a member of the Anderson County Medical Society.

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ANNOUNCEMENTS

The American Congress of Physicians will hold its 1943 Session in Philadelphia on April 13-16, 1943. Dr. George Morris Piersol of Philadelphia is chairman in charge of general arrangements and will be responsible for the program of hospital clinics, panel discussions and local arrangements.

Announcement is made by the American Board of Obstetrics and Gynecology that the next written examination and review of case histories (Part I) for all candidates will be held in various cities in the United States on Saturday, February 13, 1943, at 2:00 p.m. Applications must be in the office of the Secretary by November 16, 1942. Address all communications to Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh, Pennsylvania.

The American Congress of Physical Therapy will hold its twenty-first annual scientific clinical session on September 9-12, 1942, at the Hotel William Penn, in Pittsburgh, Pennsylvania. For information address: American Congress of Physical Therapy, 30 North Michigan Avenue, Chicago, Illinois.

Announcement has been made of a five year, \$300,000 grant to The Johns Hopkins University at Baltimore for an intensive and long time study of the disease of Infantile paralysis. The grant was provided by funds from the National Foundation for Infantile Paralysis. Three appointments have been made to the staff and others will be made to augment the three already at work.

BOOK NOOK

BOOKS RECEIVED

THE NATIONAL FORMULARY, Seventh Edition—Prepared by the Committee on National Formulary by authority of the American Pharmaceutical Association—Official from November 1, 1942. Published by the American Pharmaceutical Association of Washington, D. C.

HUGHE'S PRACTICE OF MEDICINE—Sixteenth Edition. Published by the Blakiston Company of Philadelphia, Pennsylvania. Priced at \$5.75. The volume contains 791 pages illustrated.

SYNOPSIS OF ANO-RECTAL DISEASES—Louis J. Hirschman, M.D., F.A.C.S., Ex-Vice President of the American Medical Association, Ex-President, Section on Gastroenterology and Proctology of the American Medical Association, Ex-President of the American Proctologic Society, Chairman, American Board of Proctology, Inc.; Professor of Proctology, Wayne University; Fellow (Honorary) Royal Society of Medicine; Extra-Mural Lecturer on Proctology, Post Graduate School, University of Michigan; Proctologist, Harper, Charles Goodwin Jennings and Woman's Hospital; Consulting Proctologist, Detroit City Receiving Hospital, Evangelical Deaconess, Wayne County Hospitals, Children's Hospitals of Michigan, Detroit Tuber-



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FOR SALE—Entire ultra modern medical equipment of the late Dr. Harrison B. Talbot for sale—Address Journal of The Kansas Medical Society, C-03.

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culos Sanitarium, Detroit. Published by the C. V. Mosby Company of St. Louis, Missouri. This book of 315 pages has 182 illustrations and twelve color plates is the Second Edition.

SYNOPSIS OF MATERIA MEDICA, TOXICOLOGY AND PHARMACOLOGY, For Students and Practitioners of Medicine—Forrest Ramon Davidson, B.A., M.Sc., Ph.D., M.D., Medical Department, the Upjohn Company, Kalamazoo, Michigan, Formerly Assistant Professor of Pharmacology in the School of Medicine, University of Arkansas, Little Rock. The Second Edition is published by the C. V. Mosby Company of St. Louis, Missouri, and contains 695 pages and is illustrated.

BOOKS REVIEWED

The S. H. Camp Company of Jackson, Michigan, has issued a little booklet on "Blue Prints for Body Balance" in collaboration with eminent authorities in the field of orthopedics which is being offered exclusively to physicians

who might desire to give it to their patients. The little booklet may be secured on request.

METHODS FOR DIAGNOSTIC BACTERIOLOGY (A Complete Guide for the Isolation and Identification of Pathogenic Bacteria for Medical Bacteriology Laboratories—Isabelle G. Schaub, A.B., Assistant in Bacteriology, Department of Pathology and Bacteriology, The Johns Hopkins University School of Medicine, and M. Kathleen Foley, A.B., Bacteriologist in Charge of the Diagnostic Bacteriological Laboratory of the Medical Clinic, The Johns Hopkins Hospital of Baltimore. Published by the C. V. Mosby Company of St. Louis, Missouri. The increasing importance of diagnostic bacteriological procedures in medicine give a growing demand to this type of book. The book contains a fund of information by the two authors who have had wide experience in this field, and many "tricks of the trade" are given. Much of the material is that used in the class outline in bacteriology at Johns Hopkins University School of Medicine. A good little book to add to your library.

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THE CARE OF THE AGED (GERIATRICS)—Malford W. Thewlis, M.D., Third Edition, containing 579 pages, illustrated and priced at \$6.00. Published by the C. V. Mosby Company of St. Louis, Missouri. In readably interesting form the author covers the modern conception of old age, giving under the values of old age a list of famous persons who did their best work between the ages of seventy and ninety years, among these notables are Goethe, Herbert Spencer, Oliver Wendell Holmes, Gladstone, the Drs. (sisters) Blackwell, Thomas Edison, Mrs. Osler (William Osler's mother) and Rockefeller. The book deals with the neglect of old age, and the various diseases and their treatment, with case histories frequently given. Old age has no definite date it may begin in the forties or later but it can be, if properly utilized and protected, a valuable age.

EYE HAZARDS IN INDUSTRY (Extent, Cause, and Means of Prevention)—Louis Resnick. Published for the National Society for the Prevention of Blindness by the Columbia University Press, Morningside Heights, New York. Priced at \$3.50. The total number of eye injuries each year in American Industries is estimated to be more than 300,000 and the total compensation cost to industry is believed to be more than \$100,000,000. Today there are approximately 26,880 workers idle because of some eye injury. With these astounding facts in mind and the added fact that there is no need for the blinding of workers in our industries because such accidents and diseases affecting the eyes are now known and methods of eliminating these

hazards and of protecting the workers have been demonstrated. This book, therefore, should be in the hands of all those interested such as safety engineers, safety inspectors, vocational training advisors and others engaged in training for work in industry. As a vital defense problem this is indeed a good book to read at this time.

A PRIMER OF THE PREVENTION OF DEFORMITY IN CHILDHOOD—Richard B. Raney, M.D., Duke University, and Alfred R. Shands, Jr., M.D., Medical Director of the Alfred I. du Pont Institute. Published by the National Society for Crippled Children. Priced at \$1.00. This little book of 188 pages, well indexed, is a primer on the prevention of deformity in youth and childhood. Not a text book, it is yet a valuable adjunct to the library of the general practitioners, and should be read by nurses, social workers, teachers, and all who come in contact with crippled children.

MICROBES WHICH HELP OR DESTROY US—Paul W. Allen, Ph.D., Professor of Bacteriology and Head of the Department of the University of Tennessee, and D. Frank Holtman, Ph.D., Associate Professor of Bacteriology, University of Tennessee, and Louis Allen McBee, M.S., Formerly Assistant in Bacteriology, University of Tennessee. Published by the C. V. Mosby Company of St. Louis, Missouri. A good text for the students in bacteriology and public health. Much elementary information is included such as the relationship of bacteria to the every day process of canning, the use of disinfectants and antiseptics and the

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**Laryngoscope*, Feb. 1935, Vol. XLV, No. 2, 149-154. *Laryngoscope*, Jan. 1937, Vol. XLVII, No. 1, 58-60

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CARDIAC CLINIC—A Mayo Monograph—Frederick A. Willius, B.S., M.D., M.S., Head of the Section of Cardiology of the Mayo Clinic, and Professor of Medicine, Mayo Foundation of Medical Education and Research, Graduate School, University of Minnesota, Rochester, Minnesota. Priced at \$4.00. Published by the C. V. Mosby Company, St. Louis, Missouri. The volume is an assembly of various topics on cardiac problems which have appeared previously in the bulletin of the Mayo Clinic. The cases discussed cover the most common types found in general practice with explanation and discussion of each. The internist and the general practitioner alike will benefit greatly by adding this little volume to their library.

FOOD AND BEVERAGE ANALYSIS—Milton Arland Bridges, B.S., M.D., F.A.C.P., Late Director of Medicine, Department of Correction Hospital, New York; Consulting Physician, Seaview Hospital, Staten Island, New York; Assistant Clinical Professor of Medicine and Lecturer in Therapeutics, New York Post Graduate Medical School, Columbia University; Assistant Attending Physician and Chief of Diagnostic Clinic, Post Graduate Hospital, New York; Fellow of the New York Academy of Medicine and Marjorie R. Mattice, A.B., M.S., Assistant Professor of Pathological Chemistry, Department of Medicine, New York Post Graduate Medical School, Columbia University; Chief Chemist New York Post Graduate Hospital; Consultant Chemist, Department of Correction Hospitals, City of New York. The Second Edition, thoroughly revised is published by Lea and Febiger of Philadelphia, Pennsylvania. Priced at \$4.00. With the subject of nutrition and foods an outstanding factor in health and defense this

volume of 344 pages by two authorities of note provides analytical data on a great number of food factors, and will be of great assistance to students of home economics, dietitians, nurses, welfare workers, chemists, medical students, and clinicians. New and valuable data and information has been added to this second volume such as tables on acidity of foods, fiber content, the occurrence of sulphur, bromine, calcium, oxalite, phytins, purins, carbohydrates and ionizable iron. A valuable addition to a library.

THE 1941 YEAR BOOK OF PUBLIC HEALTH—Edited by J. C. Geiger, M.D., Dr.P.H., Clinical Professor of Epidemiology of the University of California. Published by the Year Book Publishing Company of Chicago. Priced at \$3.00. The 1941 volume is somewhat smaller than the 1940 volume but contains the usual amount of fine material on this subject with the addition of papers on "Hospital Hygiene" and on "Military Hygiene." The author is well able to express the thoughts on this subject from his wealth of experience both in the present and in the past. The organization of the book is more logical than the book the year previous. A fine book full of interesting material for the public health worker or any one interested in that subject.

IMMUNITY AGAINST ANIMAL PARASITES—James Y. Culbertson, Assistant Professor of Bacteriology, College of Physicians and Surgeons of Columbia University. Published by the Columbia University Press, Morningside Heights, New York. Priced at \$3.50.

A little text book of 274 pages containing the beginning study of the parasitic forms with the fundamental principles of the subject. It includes both a knowledge of parasitology and immunology, directed to inform the beginning student, the trained investigator, and the practicing physician or veterinarian.

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PRESIDENT'S MESSAGE

Vacation greetings! I hope you are all having a pleasant summer, whether you are having your vacation miles from home or in your own back yard. Mine consists of canning vegetables from our victory garden during the day, and fishing in our lake in the evenings.

It won't be long until we get the children ready for school again and settle down to an intensive Auxiliary program. I hope the summer months will leave you feeling refreshed and eager to undertake and accomplish big things this winter!

Mrs. C. Omer West.

SHAWNEE AUXILIARY

The Shawnee County Medical Auxiliary entertained the members of the Shawnee County Medical Society at a picnic at Lake Shawnee on May 21.

Tuberculosis does not recognize appeasement. Only through the cooperation and alertness of all can we stop this needless sacrifice of life. Each case of tuberculosis is a result of the carelessness of another case. We have no known specific that can be used to break this vicious cycle rapidly, but our known available means, if properly used, will slowly eradicate this disease. Alfred M. Dietrich, M.D., Delaware State Medical Journal.

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TREATMENT OF DUODENAL ULCER*

Charles W. Mayo, M.D.

Rochester, Minnesota

When I am asked to discuss the subject of duodenal ulcer, I accept, if it seems I must, with some trepidation. My anxiety is based on the possibility of being misunderstood when I emphasize certain points in connection with the treatment of this condition, to a degree that other, also important factors, seemingly are forgotten. This results in the opinion that I am fanatical for instance, in my view on the value of water in any medical regimen which may be advocated in the therapy of duodenal ulcer.

What qualifications have I to speak on duodenal ulcer? I have not produced ulcers of this nature in the laboratory, in the monkey, dog, cat or mouse. With obvious surety, I can say that on man I have not performed the number of operations for this condition that many others have. I have followed the literature, however, have observed closely various types of diets and regimens prescribed for patients who have this malady, have operated on my share of patients and have followed them with interest, and last, but not least, I have an ulcer tendency myself. If anyone wants to develop an unusual interest in this subject, I would say, get an ulcer.

There are two types of treatment for duodenal ulcer, namely, medical and surgical. In the process of development of the present attitude toward treatment, there was a time when the diagnosis, once made, brought forth the almost imperative advice for surgical intervention, regardless of the question of complications. Although there is today by no means complete understanding of the etiology or, for that matter, cure of duodenal ulcer, at least surgeons have become more conservative as to the cases they accept and surgical treatment on the whole has tended to become more radical in those in which operation seems indicated.

Many etiologic factors are concerned with the formation of peptic ulcer; among them are acid aggression, limited tissue defense, the neurogenic factor, infection, vascular changes, nutritional factors and trauma. When all are analyzed, the one which seems to predominate and which defies accurate evaluation is the hereditary factor, the inherited tendency for duodenal ulcer to develop under individually specific circumstances.

If a physician wishes to say that the neurogenic, or the acid, factor usually is the etiologic factor of greatest moment, I would agree because that is one of the inherited characteristics of that particular person. If heredity is an acceptable basic cause for peptic ulcer, then surgical treatment in itself has no control over the causative factor; in other words, it could not change the mother or the father of the patient. I do not mean to imply by this statement that surgical treatment accomplishes nothing for these patients if the operation is properly selected and properly carried out. The implication is, however, that heredity is a reasonable peg on which to tie the explanation of the limitations of operations for that group of patients who fail to take into account the importance of controlled living habits after operation, just as they probably failed to consider them before operation.

MEDICAL TREATMENT IN GENERAL

The treatment of duodenal ulcer is essentially a medical problem. Certain complications which may develop as a result of inadequate treatment of duodenal ulcer may necessitate surgical intervention but still it must not be forgotten that operation is not a substitute for a rational medical regimen. If, as a surgeon, I seem to spend an undue amount of time on the medical aspects of this pathologic process, it is because of my intense feeling that the medical aspect of the problem is extremely important. It seems to me that the answer to the question of why this or that patient did not respond to what was thought an adequate medical regimen or a good surgical procedure will be found in failure on the part of physicians to appreciate fully the medical aspect of the problem, to explain properly the fundamentals of treatment to patients and to see that the

*Presented at the 83rd Annual Session of The Kansas State Medical Society, Wichita, May 14, 1942.

prescribed changes of living and habits are carried out, not only today and next week but are continued indefinitely.

This brings up the question of how the patient should live when a positive diagnosis of duodenal ulcer with or without complications has been made. The answer is not simple. It is difficult, for instance, to advise the patient wisely, especially if he is a hard working man, when a previously asymptomatic duodenal ulcer perforates suddenly or produces sudden hemorrhage.

The usual medical regimen advocated for the treatment of duodenal ulcer consists of a combination of diet, rest, alkalis and bismuth; the emphasis, placed on one or another of these measures, depends on which seems best to fit the individual patient's needs. From time to time other therapeutic agents have been given by mouth or hypodermic needle and others will be devised in the future. Premature enthusiasm has prompted ill advised reports of the great value of the agent but time has judged well the impracticability of most of them.

The one fundamental principle of a successful medical regimen seems to me to be control of the acidity. In the majority of cases, if acids are controlled, symptoms are controlled. In other words, failure of a medical regimen to prevent complications, a recurrence of symptoms and development of gastrojejunal ulcer, suggest two possible faults, namely, the regimen itself or the way it is carried out by the patient.

To determine the status of these two most important points requires conscientious questioning into details, as to type of work carried on by the patient, what stress and strain he is under, his personal or family worries, responsibilities, financial and otherwise, how much sleep he gets, the regularity of his habits, and his habits of smoking, drinking and eating. A host of factors, singly or in summation, may have much to do with the activation of duodenal ulcer.

The stupid type of individual, generally speaking, is not one who is subject to this trouble; usually the patient is one somewhat above the average in intelligence. The remark once was made, namely, that if you would assure yourself of a good salesman, hire one with a duodenal ulcer. It is reasonable to assume that in order to obtain optimal co-operation from the patient in carrying out any medical regimen, the background of the disease process and also the reasonableness of each step in the medical regimen which is to be followed should be explained to him.

Six points among others on which it is well to lay particular emphasis in this talk with patients are as follows:

First, malignant disease which develops primarily in the upper portion of the duodenum as a result of duodenal ulcer is so rare that its possibility can be practically disregarded.

Second, smoking, moderate drinking or eating of a particular type of food may be tolerated without ill effects by one person and not by another. All cases are different and the treatment, consequently, must be individualized. In one case, a cigarette may raise the gastric acids thirty to forty unit points and, in another, it may not produce any perceptible change. Therefore, if an ulcer "speaks up" after a patient has been smoking, it hardly should be necessary for a physician to order the patient to stop smoking or reduce it materially; the patient should know this himself.

Third, an ulcer is a barometer, a dictator, which, when reactivated, is trying to tell its host that something is being done in a mental or physical way which is affecting adversely the chemistry of the stomach. The patient must be a detective and try to interpret what it is that has been done which the ulcer did not like and then avoid it. It may be a hard game but it is an important one.

Fourth, there are all degrees of duodenal ulcer and tendencies to them. Some are controlled easily, some with difficulty and some, unfortunately, can scarcely be controlled by any available means, medical or surgical. None are controlled permanently without some effort on the part of the patient.

Fifth, a certain analogy exists between duodenal ulcer and tuberculosis. One method of awakening a different viewpoint in the patient is to suggest to him what he would have been told if, instead of ulcer, active tuberculosis had been found. When active tuberculosis is present, the layman has been educated to realize, accept and adjust himself to prolonged isolation and hospitalization. On his dismissal from this supervised care, the disease is not considered cured but arrested. Unless a definite regimen is adhered to after dismissal from the hospital symptoms may become reactivated and rehospitalization may be necessary. When the duodenal ulcer is quiescent and symptoms are absent, the patient is living within the limits laid down by his ulcer. If he breaks over this barrier, beyond a specified degree, or for a long enough time, reactivation resulting in a return of symptoms assuredly will take place.

Sixth, the dilution theory should be explained in simple terms as dilution is an assisting factor in the control of gastric acids. I usually begin by finding out if the patient uses soda for the relief of symptoms and the average amount of water he uses each day (each day in the year, not only last week) and how he takes it. Soda relieves pain temporarily in many

of these cases but may have to be repeated within a short time to relieve more pain. The reason that only temporary relief is obtained by this means is that the soda neutralizes the acids and following its ingestion, the acid producing cells of the stomach pour out acid to neutralize the alkalis; these cells do not stop when this has taken place but simply follow the law that for every action there is an opposite and equal reaction. If soda, other alkali or a product, such as aluminum phosphate gel, is deemed necessary, the importance of dilution should not be neglected when it is taken. It should be combined with at least one full glass of water and, preferably, two full glasses. I explain to the patient that if one drop of hydrochloric acid is placed in a thimble full of water, it tastes strong; if it is placed in a full glass of water, it cannot be tasted.

The dilution of gastric acids by water has another and appealing feature; it is the cheapest medicine on earth. The quantity necessary in each case varies. Two glasses a day cannot be built to ten tomorrow without some discomfort, and so the build-up should be gradual, but a minimal intake eventually should be set and maintained. This intake should be distributed throughout the day until a new and valuable habit has been created which from then on will be no chore.

The idea is so simple that it has been neglected but, reasonably, it is one of the most important points in any medical regimen which will give prolonged and distinct relief of symptoms. In my estimation, a medical regimen which has not included a high intake of water has not been an "adequate" regimen. In my opinion, milk, coffee, tea or beer are not adequate substitutes for water, although milk is an excellent food and is indicated when no allergic manifestations to it are found.

No physician should take literally the answer of a patient when he states, "I drink lots of water." The physician should find out for himself how much the patient drinks by a little closer questioning. I have yet to see a jejunal ulcer develop in a case in which the average intake of water is more than three glasses a day; in most cases, the average intake is less than this.

There is one more point in connection with the drinking of water; in the summer when perspiration is free, some salt should be added to the water in order that the salt balance of the body will not be upset.

Perhaps after this exposition on the subject of water, some readers of this paper too will agree with others that I am fanatical on the subject. My defense is that it seems to work in many cases in which other more difficult and expensive regimens have failed.

It is by no means the complete answer but must be combined with the other reasonable measures of a good regimen for duodenal ulcer.

The manual worker can carry water in a canteen, thermos bottle or jug; the office worker should keep it on his desk and never pass a drinking fountain without leaning over and taking a few swallows.

SURGICAL TREATMENT

Preferably before operation, but if not then, certainly after operation for duodenal ulcer, and regardless of the type of operation that has been performed, matters just mentioned should be discussed thoroughly with the patient so that he will agree to carry on continuously a certain, medical regimen which will fit his individual needs. Failure to do this has cast a dark blot, undeservedly, on many surgical methods of dealing with the so-called intractable ulcer.

There is a place in the surgical armamentarium for every operation devised for duodenal ulcer if the type of operation has been properly selected in each case and the technic properly executed.

The same guiding principle can be used in operations for this condition that is useful in most other conditions, namely, a careful weighing of the risks involved in surgical intervention, and comparison with results which may be expected from it. A death from surgical treatment of a benign condition, regardless of cause, is much less excusable than one from operation for a malignant condition.

Each case of duodenal ulcer can be classed into one of three groups according to the treatment indicated: (1) definitely medical only; (2) definitely medical but indefinitely surgical, and (3) definitely surgical and medical. The first group has been considered already. The second group I can dispose of after due consideration by the statement, "When in doubt, don't operate." Consultation should be called but unless the surgeon conscientiously can accept the responsibility, not only for the short pull but also for the long pull, he should let someone else shoulder the surgical problem if he wishes. Treatment should be considered as medical only until time has proved the correctness of the judgment or the condition has developed to a point where transfer of the case into the third group is definitive.

It may be of some interest to know that a review of the last few years' experience with duodenal ulcer at the Mayo Clinic revealed that operation was undertaken in only between twelve and fifteen per cent of the cases of duodenal ulcer encountered.

The generally accepted indications for surgical intervention are hemorrhage, perforation, obstruction and failure of a fair trial of good medical man-

agement, but even these are not dictatorial precepts for imperative surgical intervention at all times.

Hemorrhage.—Hemorrhage may have occurred one or more times in the past, or may be active when the patient is seen. According to some reports in the literature bleeding may be expected sooner or later in twenty-five to thirty-five per cent of the cases of duodenal ulcer, but this, to me, seems a pessimistic opinion. Despite the fact that some excellent physicians have advocated immediate surgical treatment in cases of massive hemorrhage, present opinion remains divided. Surgical intervention as a rule of approach to this problem for patients less than forty-five years of age cannot better to an appreciable extent, if at all, the results from medical treatment of patients in this age group. The mortality rate of the patients in this group who are treated medically is low. For patients beyond forty-five years of age who are treated medically, the mortality rate has been estimated as varying between ten and thirty per cent, or higher. It is reasonable, therefore, to assume that immediate operation in such cases may well have a field of usefulness. It is the practice at the clinic to advise surgical intervention when medical measures have failed to bring bleeding under control within forty-eight hours, or if hemorrhage recurs under good medical management. Under these circumstances the surgical attack should be directly on the ulcer, generally by resection, but under less favorable circumstances, by a transduodenal approach to control the bleeding point by suture.

The patient who has had repeated hemorrhages, I believe, is always in potential danger and generally can best be advised to submit to operation. This is particularly true if his home is removed from a place where quick and competent care is possible. Resection, properly carried out, gives excellent subsequent protection, but gastro-enterostomy does not.

Perforation.—Acute perforation, without argument, is an emergency for which surgical intervention should be undertaken at the earliest possible moment. The mortality rate increases with the time that elapses before it is undertaken. As a rule, the safest surgical procedure is simple closure of the acute perforation, which is almost always on the anterior wall or lateral border. If there is more than the usual amount of induration, excision of the indurated region and transverse closure may be best employed. In the exceptional case of acute perforation, gastro-enterostomy may be performed after closure of the blown-out point has been made.

Subacute perforation onto the pancreas of an ulcer on the posterior wall may cause symptoms which are rather difficult to control by medical measures.

This type of lesion also is likely to produce hemorrhage. Surgical intervention generally is indicated in these cases, and gastric resection gives the best results if the condition is found amenable to this procedure.

Obstruction.—Two types of obstruction may be caused by duodenal ulcer: one is brought about by an active subacute or an acute exacerbation of the lesion; the other is on a sclerotic or old scarred basis. In the first, or inflammatory, group, the obstruction is of a temporary nature and usually is amenable to a good medical regimen. Repeated episodes of this type may well mean that the patient has not taken seriously the importance of a continued medical regimen and if operation is indicated eventually, in my opinion he is a candidate for a high gastric resection without promise for the future unless he mends his way of life.

Few members of the medical profession will disagree with the statement that obstruction of long standing is a surgical problem, for operation offers so much for the patient's comfort. If this type of patient has learned how to live with an ulcer, and he will be easier to teach than most persons, gastro-enterostomy, if it is done correctly, will give relief and a high percentage of good results will ensue. If jejunal ulcer does develop because the patient has gone back to the old abnormal way of living as a result of his feeling so greatly relieved after the gastro-enterostomy, bridges have not been burned and subtotal gastrectomy is still possible.

Failure of medical management.—The failure of medical management as an indication for surgical intervention is the theme of this presentation. In this group of cases the surgeon must determine whether the treatment which has been administered actually has been adequate. If, in his opinion, all criteria for such treatment have been fulfilled, then again with no promise for the five or ten year "pull," he might operate or advise operation, but the surgical procedure should be radical. Gastro-enterostomy is not the operation of choice in these cases; high partial gastrectomy is indicated but not until the patient thoroughly understands the risks involved and the demands for a regulated life thereafter. This precaution is necessary because in this group in particular the culpability for a poor result can fall on a good operation.

Operative procedures for duodenal ulcer in general.—I repeat that there probably is a place for every type of operation devised for duodenal ulcer if the surgeon knows in which type of case to do a particular operation and how to perform the operation itself properly.

Gastro-enterostomy, performed on the foregoing principle, will result in an incidence of jejunal ulcer

of not more than five per cent of cases. The result of this procedure eventually will be worse than if operation were not undertaken, however, if the anastomosis is made too close to the pylorus, too high, too close to the greater curvature of the stomach, or if it is too small.

A plastic procedure on the duodenum is now at a low point in the cyclic phase of surgical favor but this operation also has its place in a small percentage of cases, especially those in which the upper portion of the duodenum is mobile and in which the importance of removal of most of the pyloric muscle is recognized and an adequate opening between the stomach and duodenum can be left. I have been particularly impressed by the smoothness of post-operative convalescence in this type of procedure.

Partial gastrectomy is now beginning to find its proper place in the treatment of duodenal ulcer. The overenthusiastic proponents of gastric resection, however, seem to believe that this operation precludes the formation of jejunal ulcer. This is not true, but the incidence of this complication can and will be cut down, I am sure, when the realization is brought home that the purpose of the operation is to remove most of the acid bearing cells. This is not accomplished by removal of a small or medium sized portion of the stomach; for a successful result, two-thirds to three-fourths of the stomach must be resected.

Mortality is another prime consideration when surgical intervention is contemplated. In the past five years, the average mortality rate following gastric resection for duodenal ulcer at the Mayo Clinic has been 4.1 per cent, and for gastro-enterostomy, 2.0 per cent. Dr. Priestley has asked how many jejunal ulcers following gastro-enterostomy it will take to make up for the two additional patients out of every 100 who failed to survive the gastric resection.

SUMMARY

In this paper I have tried to emphasize certain points which have appealed to me as of importance in the surgical approach to the treatment of duodenal ulcer. Treatment of duodenal ulcer is primarily a medical problem and if surgical procedures become necessary, the problem then is surgical but it is still medical as well. The approach to better results by the best surgeons is based on an appreciation of this fact.

In the presence of duodenal ulcer, the medical regimen must be individualized but continuous, and last but not least, the water dilution treatment, as an adjunct to any other medical therapy, is worth consideration, as a part of an adequate medical regimen.

ELASTIC ADHESIVE BANDAGE ON BURN OF FOOT

Maurice A. Walker, M.D.

Kansas City, Kansas

A white man, aged fifty, spilled boiling water on the dorsum of his right foot, scalding an area four by three inches. Blebs were opened, tannic acid jelly and ten per cent solution of silver nitrate applied, and the foot elevated. An eschar formed promptly, becoming a hard black smooth film densely adherent to the burned area. After two days, there was no apparent reason why he could not return to his usual work. Whenever his foot was allowed to hang down for forty to sixty seconds, however, he complained of such severe pain that he had to elevate it again. A week after he was burned he continued to complain bitterly whenever his foot was dependent.

An elastic adhesive bandage was applied around the foot, up to the ankle, directly over the eschar. He was then able to put the foot down and stand for some time without much discomfort, thus demonstrating that his previous symptoms were not due to malingering. He resumed his usual work without further loss of time. The bandage was removed after it had been on for five days, the eschar coming off with it. The scalded area was entirely covered with new epithelium at this time, twelve days after the injury.

Surgeons' Gloves—A telephone and telegraph survey of thirty-four general hospitals throughout the United States, and varying in bed capacity from 200 to 1000, showed that these hospitals used an average of 1.55 pairs of surgeons' gloves per bed per month; 18.6 pairs of surgeons' gloves per bed per year.

There is a total of 720,815 hospital beds in the general hospitals of the United States, including dispensaries of the nervous and mental hospitals and the tuberculosis institutions. These are comparable in their professional services and the use of surgeons' gloves with the other general hospitals throughout the country. Based upon the use of 1.55 pairs of rubber gloves per month in these general hospitals, there is a total monthly consumption of surgeons' gloves for this group of 1,117,263 pairs.

In the custodial and domiciliary institutions of the country, having a total of 679,726 beds, there is a limited use of surgeons' gloves by this class of institution, conservatively estimated at four pairs of gloves for each bed per month.

The gross total of all hospitals of all classifications—general, domiciliary, and custodial—is 1,343,763 pairs per month. It is interesting to note that there has been a slight increase in the use of surgeons' gloves in general hospitals during the past five years. A similar survey, but more extensive, some five or six years ago showed the use of surgeons' gloves at that time averaging six pairs per surgeons' gloves per bed per year.—Hospitals.

HODGKIN'S DISEASE COMPLICATED BY BRUCellosis

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Mr. C. K., age thirty, complained of intermittent fever, malaise, loss of weight, cough, nausea, occasional vomiting. Present illness began about three years ago when he noticed difficulty in breathing, especially on exertion; but he was always able to work as an engineer in a paint factory. About a year after onset of these symptoms a tender swelling was noted in the right cervical region; this gradually increased in size, and after it was about the size of a hen egg the patient entered the University of Kansas Hospital. There this mass was removed about eighteen months ago and the biopsy showed Hodgkin's disease. Subsequently he received x-ray treatments to his neck; this made him very sick and nauseated. He left the hospital two weeks after admission and refused further x-ray treatment; soon he began to feel better, gained appetite and weight and his dyspnea improved. He remained in fair health up to three weeks ago when he began to have intermittent fever, chills, coughing spells, nausea and vomiting.

CASE REPORT

Review of symptoms:—Ears, eyes, nose and throat: has occasional colds, but not severe. Does not wear glasses; frequent headaches. Neck: no pain or swelling since tumor in the right side has been removed. Cardio-respiratory: occasional palpitation, shortness of breath, coughing spells; no expectoration; night sweats lately. Gastro-intestinal: appetite is poor, bowels loose, nauseated, vomits occasionally. Genito-urinary: loss of libido. Rectal: no symptoms. Neurological: weak, tired, nervous. Extremities: aching in joints and muscles. Endocrine: has lost about ten pounds in the last three weeks. Skin: moist, not peeling, not itching. Allergy: no symptoms. Habits: eats a normal diet, when he feels good; sleeps about eight hours out of twenty-four, smokes about twenty cigarettes a day, uses no alcohol; has not taken any medicine for several months, except occasional aspirin for headaches.

Past history: Had measles and whooping cough at the age of five and seven respectively; influenza at eighteen; at that time was quite ill and in bed for two weeks. Never had pneumonia or rheumatism.

Family history: Both parents are alive and in good health, has no brothers or sisters; no history of cancer, diabetes or tuberculosis in the family; his wife and three children are in excellent health.

Examination: General inspection: The patient is conscious, apparently free of pain, somewhat nervous. He is cooperative. His speech is normal. Slight dyspnea is present. The patient's nostrils dilate with inspiration and contract with expiration; an expiratory grunt is heard. No cyanosis is present. Patient appears thin and underweight. Weight: 150 pounds. Height: Seventy-three inches. Temperature: 101 degrees by mouth. Skin: Feels hot, dry, no eruptions are noticed.

Head: Of normal size and shape; the facial expression is normal. The hair growth is abundant. The face is flushed. Eyes: the pupils are round, equal in size and react to light and accommodation. The ocular movements are normal. There is no nystagmus: the scleras are not icteric; the conjunctivas are pale. Examination of the retina shows nothing unusual. Ears: the outer ears of normal shape, the mastoid processes are not tender to pressure and the hearing is normal. Nose: the septum is slightly deviating to the right, both inferior turbinates are moderately enlarged; no secretion or other pathology is found in the nose. Mouth: the lips are dry and pale. The teeth are in good condition and the gums are firm. Tongue is heavily coated in its posterior half. Breath is offensive. The tonsils are embedded.

Neck: Long and thin; a wide, irregular, well healed scar about four inches long and running parallel to the clavicle is seen on the right side of the neck. A few small, non-tender cervical lymph nodes are palpable on both sides; no unusual filling or pulsation of the neck vessels is noticed. The thyroid gland is soft, not enlarged.

Chest: Inspection: the chest is thin, the spinal column normal and the movements of the spine are performed without difficulty; there is slight tachypnea, but the respiratory movements are equal and normal on both sides of the thorax; there is frequent coughing. Palpation: the tactile fremitus is increased over the right base. A few axillary lymph nodes are palpable on both sides; they are small, firm, easily movable and not tender. Percussion: there is normal resonant percussion note over all lung fields except posteriorly over the right base, where the percussion note is dull. Auscultation: the breath sounds are diminished over the right lower lobe and fine crepitant rales and increased vocal resonance are heard in the same area.

Heart: Inspection: the point of maximal impulse is easily seen in the fifth intercostal space about one cm. inside the left midclavicular line; the rhythm is regular; no other abnormalities are found. Palpation: the point of maximal impulse is felt in the fifth intercostal space inside the midclavicular line; no thrills are palpable. Percussion: the relative cardiac

dullness extends eight cm. to the left of the mid-sternal line in the fifth intercostal space; the right cardiac border corresponds to the right sternal border. Auscultation: the rhythm is normal, the tones are clear and distinct. There is slight accentuation of the second pulmonic tone as compared to the second aortic tone; no murmurs. Pulse: regular, easily compressed, 110 per minute.

Abdomen: Inspection: round, distended, no umbilical hernia is present. Palpation: the abdomen is soft, not tender, the liver is of normal size, the lower pole of the spleen can just be palpated on deep inspiration; no fluid wave is obtained and no tumor masses are felt. Percussion: tympanitic over the entire abdomen. No enlargement of the inguinal glands and no inguinal hernia is found.

Genitalia: Normally developed, no urethral discharge.

Rectum: No external hemorrhoids are seen. Digital examination reveals a normal tone of the sphincter. The prostate is normal in size and consistency and no prostatic fluid is obtained after massage. No internal hemorrhoids or tumor masses are found.

Extremities: Color and size of hands is normal, the fingers are long, the finger nails are of normal appearance. On the lower extremities there are no varicose veins and no pitting edema; On the lower extremities the pulsations are normal. No signs of arthritis are found.

Nervous system: The patient is intelligent, slightly restless. The cranial nerves function normally. The tone and power of skeletal muscles is good. A fine tremor is found in both hands, the gait is normal. Reflexes: the reflexes in the upper extremities are present and normal. The pupils react to light and accommodation; the corneal reflexes are present in both eyes. The abdominal and cremaster reflexes are normal. The patellar reflexes are hyperactive on both sides. There is no patellar or ankle clonus. There is no Babinski, Oppenheim, Kernig or Brudzinski sign. The Romberg sign is negative. The sensory function is normal. There is no special defect and the examination of the autonomic nervous system reveals no pathological changes.

Laboratory findings: Wasserman and Kahn: negative. Sedimentation rate: twenty mm. per one hour.

Blood count: hemoglobin: sixty-one per cent. R. B. C.: 3,600,000. W. B. C.: 6,000. polymorphonuclears eighty-five per cent. eosinophils: one per cent. basophils: 0.0. large lymphocytes four per cent. small lymphocytes: three per cent. monocytes: seven per cent. Icteric index: seven units. Blood sugar: (fasting) eighty-eight mgm. per 100 cc of blood. Urea nitrogen: eighteen mgm. per 100 cc of blood. Urinalysis: reaction: acid, specific gravity: 1024,

sugar: negative, albumin: two plus, microscopic: negative.

Histologic examination of the cervical lymph node, removed previously at the University of Kansas hospital gave conclusive evidence of Hodgkin's disease. Agglutination tests for typhoid and paratyphoid, as well as examination of the blood for malarial parasites were negative. Brucella agglutinins were present in high titer on several occasions (highest 1:1280). Repeated blood cultures remained sterile.

Repeated examinations of the sputum were negative for acid fast organisms or pneumococci. X-ray of the chest: "A well developed thorax maintains a normal symmetrical expansion and no abnormalities of the diaphragms. The costophrenic sinuses clear, possibly a very minor pleural thickening over the right costophrenic sinus. The significant finding at this time is a rather coarse patchy nonspecific respiratory infection involving the lower bronchial and interstitial areas, most intense on the right side. No definite bronchiectasis or excavation of the lung structure, but a rather severe soft patchy reaction about the lower bronchial trees and carried deep into the periphery of the right side. The upper lung fields entirely clear on both sides with minimal, if any, involvement at the base on the left side. The heart, vascular pedicle and superior mediastinum all seem within normal limits. We are interpreting the abnormal findings as a subacute bronchial and interstitial pneumonitis and a recent true bronchopneumonia at the right base not excluded."

Discussion of diagnosis: The diagnosis of Hodgkin's disease in this patient was furnished by the histological examination of an excised cervical node. Without this information tuberculosis, lymphosarcoma, lymphoblastoma, lymphocytic leukemia, infectious mononucleosis, syphilis and secondary carcinoma of the lymph nodes would have to be considered in the differential diagnosis.—It must be kept in mind, that tuberculosis may occasionally coexist with Hodgkin's disease, but repeated sputum examinations and the x-ray findings eliminated this possibility in this case.—Lymphosarcoma and lymphoblastoma simulate Hodgkin's disease even more closely than does tuberculosis and the exact diagnosis must always be made from the histologic examination of the excised node. The blood picture of lymphatic leukemia will immediately determine the diagnosis unless one is dealing with those rare cases of leukemia in which for temporary periods the leukocytes approach the normal in number and proportion.—Infectious mononucleosis can be determined by its acute course, by the blood picture and the appearance of heterophile antibodies.—The Was-

sermann reaction is of help in distinguishing gummatous lymph nodes of syphilis from Hodgkin's disease.—The enlarged cervical lymph nodes which are the seat of metastasis from carcinoma can be differentiated from Hodgkin's disease only by biopsy. The mediastinal form of Hodgkin's disease is common and important. In it are seen some of the best examples of infiltration, for the lungs, the bronchi or other neighboring structures are extensively invaded. It has been stated, that lymphosarcoma provides one of the commonest examples of mediastinal tumor. The patient presents a tragic picture with all the symptoms and signs of mediastinal tumor: cough, dyspnea, orthopnea, pain and other evidence of pressure supervene. It is in this form that pulmonary lesions are most frequent.—With the diagnosis of Hodgkin's disease definitely established by biopsy of a cervical lymph node the pulmonary findings in our patient were assumed to be caused by intrathoracic lesions with involvement of the lung parenchyma, although the roentgenogram did not show large mediastinal glands. It was important to eliminate the possibility of coexisting pneumonia in this patient, as he presented some rather typical findings on examination but the laboratory did not substantiate the physical signs. The sputum was not rusty and tenacious and did not contain pneumococci nor did it show the predominance of any particular organism on repeated examinations. Leukocytosis was absent throughout the patient's stay in the hospital and all blood cultures were reported sterile.

The blood changes in Hodgkin's disease are so inconstant that little aid is obtained from the blood examination. An anemia is common. This patient has a well marked hypochromia without microcytosis. This anemia is perhaps due to toxic interference with the synthesis of hemoglobin or to a disturbance in iron utilization.

The diagnosis of brucellosis in this case was based entirely on the positive agglutination test for undulant fever. The coexistence of brucella infection and Hodgkin's disease has been demonstrated before, but the possible relationship of the two diseases, if any, is obscure. It would certainly be premature to state that brucella is the etiologic agent in Hodgkin's disease. But could it be possible, that this patient had a brucella infection which simulated a clinical and histologic picture of Hodgkin's disease?

Final diagnosis:

1. Hodgkin's disease
2. Interstitial pneumonitis, right base
3. Hypochromic anemia
4. Brucellosis

Treatment: Although x-ray is at the present the most valuable therapeutic measure in Hodgkin's dis-

case, it was nevertheless not employed at this time, first because the patient absolutely refused this form of treatment and second because there were no localized glands and the intrathoracic lesion could not be definitely diagnosed as mediastinal form of Hodgkin's disease. The best results with x-ray therapy are obtained in those instances where it is used to reduce the size of the tumor masses and thereby controls or eliminates much discomfort as well as the pain that comes from pressure upon nerves, the trachea and bronchi. We still do not know whether Hodgkin's disease is an infectious granuloma or a neoplasm and we have no specific form of treatment. The coexistence of brucella infection in our patient as well as the somewhat indefinite pulmonary findings prompted me to administer sulfanilamide, as it has apparently proved beneficial in some cases. From three to four gm. were given every twenty-four hours, the amount being governed by the blood concentration which was held between six and ten mg. per 100 cc of blood; daily urine examinations and blood counts were also ordered. The general measures advocated were rest in bed, forcing of fluids, ice caps and phenobarbital as needed for restlessness. The troublesome cough was controlled by codeine grs one-half hypodermically. The patient was transfused on three different occasions with 500 cc of blood from a suitable donor.

Results: Forty-eight hours after sulfanilamide therapy was begun the patient's temperature fell by lysis, reached normal levels on the fifth day and remained normal throughout his stay in the hospital. Coincident with the fall in temperature there was a marked general improvement in the patient's clinical condition. The dosage of sulfanilamide was cut to one half the previous amount and continued for seventy-two hours, after normal temperature and pulse rate had been obtained. There were no toxic effects of sulfanilamide. The patient's appetite improved markedly and he gained eight pounds in weight during his stay in the hospital. The final x-ray examination showed a "very definite improvement" of the pulmonary pathology and the laboratory reported blood counts well within normal limits. The sedimentation rate was now ten mm. per one hour, the icteric index five units and the urine was free of albumin. A final attempt to grow brucella on special blood culture was not successful, but a skin test with 0.1 cc of 1:1000 solution of brucellin was positive after forty-eight hours. This patient is still under observation one year after leaving the hospital; his subsequent course was characterized by occasional fever of the Pel-Ebstein type, for which he promptly takes a course of sulfanilamide; the remissions, following this form of therapy, are probably a coincidence, unrelated to the treatment. Nev-

ertheless this young man has been able hold his job as an electrical engineer, has gained another ten pounds in weight and besides a dry moderate cough, feels perfectly well at this time. A few small, firm, non-tender cervical nodes are still palpable, but they have not increased in size. Repeated x-ray examination of the chest during the last year does not show any intra thoracic lesions and physical examination is negative.

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Physician's Car Ranks as Needed Equipment: In a profession that is no respecter of timetables, the physician's car is just about as much a part of his professional equipment as his stethoscope or thermometer.

Such statistical facts, gleaned from nation-wide study of the motor car's use, cannot measure the benefits to the sick and suffering which have resulted from the swift mobility of the doctor's car. Resident's of rural areas, who had been far from a doctor's service in the horse-and-buggy days, are especially aided.

For all car-owning physicians, the average number of round trips annually per car was found to be 947, of which 842 trips or nearly ninety per cent of the total were credited to necessity purposes. Naturally, the length of the trips vary from a few blocks to many miles, depending on the doctor's location and the range of his practice.

In rural areas, one-half of the trips made by doctors for business purposes average more than fifteen miles in length. In larger cities, four out of ten physicians' cars average this distance or more. (As it is not unusual for a doctor to make a series of calls on a single trip, the city practitioner may cover a considerable distance before returning to his office.)

Of all groups of car users, the doctors' cars rank next to the top, their average distance traveled in a year being 12,932 miles per car. And, according to surveys, necessity driving accounted for 8,640 miles of the total. By comparison, traveling salesmen who lead the occupational list of car users, have an average annual mileage of 18,791 miles, although their number of round trips is less.

The doctor's annual total of 12,932 miles per car is more than twice as high as the 5,750 miles rolled up by farmer-owned cars. And the use frequency of 947 round trips a year reported by the doctors is nearly two and one-half times the 392 trips averaged by the farm car; yet, on a percentage basis, sixty-six per cent of the doctor's mileage and exactly the same figure for farmer's mileage are for economic purposes.

Occupations which require high mileage and constant use tend to have new or later model cars, as their owners follow a practice of trading frequently. Doctors are in step with this practice. Survey figures show that eighty-nine per cent of the doctors' cars were less than five years of age and that thirty-three per cent were one year old or less at the time of a recent count.—*Automobile Facts*.

THE FAMILY PHYSICIAN AND THE PSYCHONEUROSES

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Strecker's estimate that seventy-five per cent of the clientele of the general practitioner over the first ten years of his professional life consists of neuroses or somatic disorders associated with or complicated by neuroses, if correct would justify a consideration of the advances made in the study of these conditions. Unfortunately for the general practitioner references to these advances occur in journals to which he does not have ready access and seldom appear in medical journals devoted to the interests of the general practitioner. However, the above statement coupled with the fact that fifty-two per cent of our annual morbidity is due to nervous or mental disorders that manifestly develop in the clientele of the general practitioner justifies a brief appraisal of more recent efforts to clarify our somewhat hazy conceptions of their relationship to the field of general medicine.

Long established habits of thought and an attempt to grasp and assimilate psychological theologies as these relate to the so called psychoneuroses has resulted in numerous and frequently complicated postulations, the validity of which are extremely doubtful and because of their obscure foundations cannot be proven. Neither can they be successfully disproven and while accepting these as the only present tenable approach to those conditions that have been known and designated as psychoneuroses, more material and concrete evidence based on experimental data seems necessary in order to establish irrevocably the purely psychological genesis of these disorders. Recently many contributions to literature in relation to the interpretation of certain physiological phenomena associated with these disorders has occasioned renewed interest. It is only comparatively recently that physiologists have attacked the problem of these conditions and in the short period of time that research has been directed to the solving of these, much of extreme interest has been developed.

We are becoming less and less enthused over the use of unsatisfactory and inaccurate terms such as conflicts, complexes and mechanisms, that while accepted as a standard terminology infer very little that is precise or scientific and it is postulated by those whose concern with objective research rather than with speculative theologies that we are approaching an era when these phenomena may be interpreted in terms of physiologic function rather than as purely psychogenic disorders.

Conditions recognized under the caption psychoneuroses are of various types, some of which particularly the manifestations of hysteria with its anesthesias and paralysis, its profound impairment of special senses while not lending itself specifically to any physiologic explanation presents many features that probably in the future will be clearly elucidated and explained on physiological grounds as disturbances of physiology dependent upon emotional reactions. Those more common psychoneurotic manifestations that include a wide variety of complaints attributed by the patient to various peripheral organs or structures may eventually be fully explained on the basis of malfunction, not of the mind alone but of physical structures thrown into a state of imbalance by emotional stress. While it is difficult to escape from familiar terms such as neurasthenic, psychasthenic, neurotic and so forth, we are convinced that these reflect only theories in which earlier psychologic and general clinical experience have been intermingled. Recent advances in the field now seems to justify a reorientation that might perhaps change the viewpoint of the profession in relation to the etiologic factor concerned in their development involving less of theory and more of proven descriptive research.

Modern science is rapidly producing instruments of precision in which electrical measurements of neuromuscular states during phases of mental activity may be demonstrated. Again the problem of how nerve impulses are transmitted promises soon to be solved by the neurovoltmeter. A more intensive study of nerve and muscle potentials may no doubt be determined as a result of the use of these new appliances that will serve to clarify many points that are now obscure or at best are but hypotheses. The measurement of actual potentials of peripheral nerves is now possible with reasonable accuracy and progressive studies of the sympathetic or parasympathetic systems as these function as mediators in the control of bodily function has lead to valuable discoveries of their significance in the regulation of those emotional factors in response to definite bodily changes and needs, particularly those covering vascular and bodily nutrition.

The role of the thalamic and hypothalamic structures, the cortico-thalamic relationships and the part played by the hypophysis have not as yet been clearly demonstrated but we feel that these relationships will within the next few years of research be fully established and proven. Jacobson in a recent article in the *American Journal of Psychiatry* arrives at the following conclusions.

"The view is presented that investigations on the electrophysiology of mental activities, although still

in their infancy, have opened the way toward understanding and treatment of various common psychoneuroses according to physiological principles. It is suggested that certain more or less vague and figurative terms in current usage should be replaced by others more precise and descriptive but less theoretical in character. Among these is the term psychoneurosis. Most of the variable conditions included under this caption can be diagnosed as neuromuscular hypertension with pathological habit formation. Foundation for this revision lies not alone in the present studies but particularly in the vast literature concerning investigations on habit formation and on conditioned reflexes.

Nervous and muscular states in man can now be measured accurately in the clinic, affording objective means of determining the progress of the patient or of testing the effects of any particular form of therapy.

"Assuming that the symptoms of the psychoneuroses essentially include neuromuscular tensions in various bodily localities, it would seem evident that the relaxation of these tensions would be the direct route to efficacious treatment, particularly if it could be made habitual."

A recognition of the shortcomings of our present interpretation of disorders that were usually classified as psychoneurotic or psychogenic resulted in the publication of the journal *Psychosomatic Medicine* whose primary function was an attempt to correlate mental, emotional, and physical phenomena not infrequently associated with or provocative of, determinable physical findings. Previous to the launching of this journal there had been desultory contributions from time to time based on fairly credible experimental evidence that conditions which had been considered purely from the standpoint of psychogenesis presented certain physiological and physical components requiring consideration in their treatment. As this conviction became more and more firmly established it was thought that the field of psychosomatic medicine was sufficiently broad to justify a journal devoted entirely to consideration of the relationship between the mind and various bodily functions that might be altered through emotional channels and according to more modern writers the conclusion has been reached that most of the conditions under discussion commonly classified as neurotic and psychoneurotic, interpreted in physiologic terms are forms and effects of neuromuscular hypertension associated with pathological habit formation. The foundation for this postulation is established not only by present investigations but by much that has previously been established concerning habit forma-

tion, both in human and comparative psychology and on the phenomena of conditioned reflexes. While much of the data upon which the more modern postulations are based has resulted from extensive animal experimentation it has been demonstrated that these primary habits induced in animals, present identical evidences of neuromuscular hypertension with those found in the human subject. It has been found that it is unnecessary to bring about these conditions of nervous excitement in the human being by severe shock to determine the increase in actual potentials both in voltage and frequency and even under states of complete rest these are demonstrable with the modern methods employed by research workers. Chronic states of nervous excitement according to Jacobson include those with manifest external symptoms but also many where these cannot be determined or that escape discernment are demonstrated quite clearly by electrical measurements that may reveal a more or less sustained or recurrent state of increased neuromuscular activity.

It has been suggested that our terminology be amended to convey a more satisfactory concept by classifying these conditions as conditions of neuromuscular hypertension. It is contended that we have been neglecting to consider the psychophysical activities which constitute these conditions that we classify as psychoneuroses, and it is postulated that any theory which neglects significant aspects whether psychologic or physiologic will require corresponding supplementation and revision. It is not felt by modern investigators that the entire structure of our present concept be torn down and rebuilt but rather than certain important physical components be included in the consideration of these conditions in order that we may be more capable of a satisfactory interpretation of the phenomena they present.

It is pointed out that this condition of muscular hypertension due to emotional states is not confined to the skeletal muscles but is equally applicable to the musculature of portions or the whole of the alimentary tract and vascular system and that many symptoms recognized as somatic manifestations are due to disturbance of tension of visceral musculature.

The want of energy is one of the main reason why so few persons continue to improve in later years. They have not the will Hardly any one keeps up his interest in knowledge throughout a whole life. The waxen tablet of the memory, once so capable of receiving clear impressions, becomes hard and crowded The student, as years advance, rather makes an exchange of knowledge than adds to his stores.—Jowett's Introduction to Plato (Quoted by Osler on flyleaf of his "On the Educational Value of a Medical Society.")

CANCER OF THE AMPULLA OF VATER

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Cancer of the ampulla of Vater is a relatively infrequent disease, occurring in only 0.04 per cent of large autopsy series. To date, there have been some four hundred cases reported in the literature.

The symptoms are frequently vague and the diagnostic measures are largely uncertain. Because of its location, cancer of the ampulla causes relatively early obstruction of the common bile duct and the symptoms of this disease are essentially those of duct obstruction. That is, most frequently there occurs the gradual development of jaundice along with anorexia, vomiting, chills, fever, and epigastric or right upper quadrant pain. These symptoms and signs are usually in the presence of a palpable gall bladder.

The lesions most simulating ampullary cancer are cancer of the head of the pancreas and the so-called "silent calculus" of the common bile duct. There are certain minor differences which may be of aid in the differential diagnosis. The most important of these is that ampullary lesions usually bleed and occult blood can be found in the stools in about eighty per cent of the cases. Another frequent occurrence with cancer of the ampulla is intermittency of jaundice. This is probably due to fragments of the friable lesion breaking off and discharging into the duodenum and thus temporarily relieving the obstruction.

Roentengenographic examinations are not conclusive but Cooper states that eight out of ten cases showed definite duodenal pathology. This varied from irritability to complete obstruction of the duodenum. One case had a definite filling defect at the level of the ampulla.

Operative measures are roughly divided into palliative and curative procedures. Nothing further need be said about the palliative procedures such as cholecysto-enterostomy except to note that in most reported series they carried about the same mortality as the more radical, curative procedures.

There are two main types of curative procedures. One is the trans-duodenal resection of the ampulla with reimplantation of the common bile and pancreatic ducts into the floor of the duodenum. The other may be performed in stages and consists of a gastro-enterostomy and cholecyst-enterostomy or choledoch-enterostomy followed by resection of the head of the pancreas and of the entire second portion of

the duodenum. The stump of the pancreas may be sutured into the efferent duodenal segment or the pancreatic duct may be simply ligated.

Results of the surgical extirpation of ampullary lesions have not been very good. There has been a large percentage of recurrences but there have also been a number of five year cures and, in general, patients who survive resection live longer and are more comfortable than those who have simple palliative measures.

The following is a case report of a patient suffering from cancer of the ampulla of Vater.

The patient was a forty-five year old white male who had enjoyed general good health until March 1941. At this time he received treatment in Stormont Hospital for a typical labor pneumonia, from which he made an uneventful recovery. However, following this attack, he never regained his former sense of health and he noted lassitude and loss of "pep". There was a gradual and sustained weight loss of twenty pounds. The general sense of weakness increased and he began having night sweats. In December 1941 he went to a clinic for diagnosis of his condition and while he was there he had several chills and sudden temperature elevation concomitant with the development of tenderness and pain in the right upper quadrant. The W.B.C. count was 13,500 with seventy-five per cent polys, twenty-two per cent lymphocytes, and three per cent monocytes. The urinalysis was repeatedly negative as were all the agglutination tests and cultures of the blood and urine. Clinical jaundice developed and the icteric index rose to thirty-two. The index subsided to twenty-two before he left the clinic. Gastro-intestinal series were entirely negative. The gall bladder failed to visualize with two attempts at cholecystograms. He was dismissed from the clinic, much improved, with the diagnosis of subsiding acute cholecystitis.

Following his discharge from the clinic on January 1, 1942 the jaundice gradually and almost completely subsided. He had regular bowel movements and the color of the stool was normal. His appetite was fair and he had no abdominal pain. On January 8, 1942 he had a shaking chill and he entered Stormont Hospital for further treatment. Examination showed a well developed male not appearing to be acutely ill. There was a slight icteric tint of the skin but not of the sclerae. The remaining examination was entirely negative except for the abdomen. This was soft, not distended, and in the right upper quadrant was a rounded, tender mass which descended with inspiration. The mass could not definitely be distinguished from the liver border and it was thought to be the gall bladder. The urinalysis was negative and the WBC count was 11,500 with sev-

enty-seven per cent polys and twenty-two per cent lymphocytes. The icteric index was fourteen. The blood urea and urea nitrogen were normal and the blood Kahn was negative.

He was put on a high carbohydrate, low fat, diet and he was given two liters of five per cent glucose solution intravenously every day. He was also given vitamin K and sulfathiazole. His temperature spiked from normal to 102.6 on January 9 and then fell to normal only to rise to 102.4 on January 10 and then was normal throughout the following day. During



Tumor of Ampulla of Vater, removed at operation.

this time he had no subjective symptoms other than a slight chilly sensation and profound fatigue. The icteric index did not increase.

It was felt that no clear cut diagnosis was possible and because of the right upper quadrant mass it was deemed advisable to perform an exploratory laparotomy. This was done on January 12, 1942, a right upper rectus, muscle splitting incision being made. The abdominal contents were normal except for a distended, thin walled gall bladder and a slightly enlarged liver which was involved with a hepatitis typical of biliary obstruction. The gall bladder was aspirated of thick green bile but no calculi were found. The common duct was not distended. The

duodenum was not enlarged but in the second portion a rather freely movable mass two centimeter in diameter was palpated within the lumen of the bowel. A two inch incision was made along the long axis of the duodenum beginning about two inches below the pylorus. The mass was found to represent a tumor of the ampulla of Vater which was projecting into the lumen of the duodenum. There was a common opening of the pancreatic and common bile ducts and this was reduced to the size of a small probe. The tumor was not fixed and there was no evidence of metastases so a transduodenal excision of the ampulla was performed. The common bile duct and the duct of Wirsung were severed as far distally as possible and then reimplanted and sutured into the floor of the duodenum. A small catheter was left in the pancreatic duct to assure its patency. Both the posterior and anterior incisions in the duodenum were closed in layers. A rubber tube drain was pursestringed into the gall bladder and brought out the mid-portion of the incision. The wound was closed in layers with chronic catgut and nylon retention sutures.

Post operatively he was put on Wangenstein suction, intravenous glucose and intravenous vitamin C. The drainage of bile from the cholecystostomy tube was profuse for the first four days. On the fifth postoperative day, thin, foul smelling fluid began draining from the incision and the following day it was evident that this represented a duodenal fistula. There was considerable excoriation of the surrounding skin and on the seventh postoperative day the wound disrupted to an extent that the abdominal organs were visible although not protruding. A few through and through nylon sutures were placed under local anesthesia for secondary repair of the wound. The irritant drainage continued to be profuse from the wound so a low pressure suction pump was applied to keep the skin dry. From his first postoperative day on his temperature never was below 101 degrees rectally and sulfathiazole seemed to have no effect. He grew progressively weaker in spite of frequent transfusions which brought his RBC count to 6.7 million with 118 per cent hemoglobin on the ninth postoperative day. At this time a jejunostomy was performed under local anesthesia and a tube was sutured into the jejunum so that nutrient fluids could be injected into the intestinal tract. The duodenal fistula drainage was mixed in equal amounts with a mixture of liquid jello and beef broth and this was allowed to drip through the jejunostomy tube at the rate of 3000 cc daily. There was no abdominal distension at any time throughout his course and his lungs remained clear. He was given 500 cc of blood plasma on the tenth postoperative day. His course was gradually and progressively downhill and

on the eleventh postoperative day he rather suddenly developed a respiratory stridor and expired.

Pathological diagnosis of this ampullary tumor was adeno-carcinoma.

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Journal Commends Selective Service Action on Rehabilitation.—A recent announcement that a program for rehabilitation of those rejected by Selective Service as physically unfit is to be submitted to the War Manpower Commission rather than undertaken by Selective Service is commended by The Journal of the American Medical Association for August 8.

In papers presented at the annual session of the Association in Atlantic City in June and published in the August 8 issue of The Journal of the Association, Major Gen. Lewis B. Hershey, Director of Selective Service, and Col. Leonard G. Rowntree, M.D., Chief of the Medical Division of Selective Service, told of the rehabilitation program test which was conducted in Maryland and Virginia. They said that the results obtained there did not warrant the adoption of the program by Selective Service, but that rehabilitation is a method by which the nation's manpower may be made more efficient. Commenting on the announcement, The Journal says:

"Elsewhere in this issue appear two contributions of great importance to the medical profession. From the moment when Selective Service first began to function, the complete cooperation of physicians was tendered to it. The calm judgment of General Hershey and the work of his medical staff in the National Headquarters have been outstanding for their wisdom and efficiency. Although innumerable attempts have been made to stampede the Selective Service System into various rehabilitation, physical fitness and what not—its leaders have held steadfastly to their main objective—the securing of a sufficient number of men sufficiently fit to meet the varying needs of the armed forces. As pointed out by both General Hershey and Colonel Rowntree, the Selective Service System has at the same time cooperated fully in maintaining both premedical and medical education, in retaining essential physicians for teaching the civilian population, and in the conduct of pilot experiments to determine the worthiness of such programs as prehabilitation and rehabilitation before establishing them on a national scale. Apparently General Hershey has concluded that rehabilitation is 'one of the methods by which our manpower may be made more efficient' but that 'the results obtained to date do not justify a program of physical rehabilitation by Selective Service.' The program is therefore being submitted by General Hershey to the War Manpower Commission. The medical profession will commend the type of scientific study and decision that have been exemplified by the leaders of Selective Service in this phase of their work. The procedure may well serve as a model for a functioning democracy."



ACUTE INTESTINAL OBSTRUCTION

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Acute intestinal obstruction is a surgical disease which has interested the clinician for many years. Quite voluminous literature dealing with this subject has accumulated through the years, but only in the last few years beginning with the studies of Wangenstein, has a true appreciation and basic understanding of the disease developed. The present review is a study of a consecutive series of cases in which an attempt has been made to correlate, and evaluate the pathology, operative procedure, pre and post operative care, and various other factors as regards their influence on the mortality.

The records of St. Anthonys Hospital in Oklahoma City, Oklahoma for the ten year period from January 1, 1930 to January 1, 1940, have been carefully reviewed and studied. Only those cases operated were selected for study because of the few cases treated conservatively, records were not sufficiently complete to permit careful and proper evaluation of the diagnosis or result. Cases selected for final study were those in which the diagnosis was proven either at operation or at post mortem, and was limited strictly to cases of acute obstruction. Long standing, low grade, partial obstructions which suddenly became acute were not studied in this series; accordingly, pyloric obstruction due to either ulcer cicatrization or carcinoma and carcinoma of the large bowel of symptomatic long standing were excluded.

Thus this review comprises a study of 134 cases of acute intestinal obstruction which were admitted and operated at St. Anthonys Hospital during the last decade. These 134 cases were under the care of thirty different members of the attending staff, and consequently no specific routine was followed in the management of these cases.

INCIDENCE

Between January 1, 1930 and January 1, 1940 there were 76,140 general admissions to the hospital, of which 134 were proven cases of acute intestinal obstruction. The incidence rate of this disease as regards general hospital admission is therefore 0.176 per cent.

There were seventy-one males and sixty-three females operated for this disease during the period covered by this review. All but five were of the white race; three were Negroes and two were Indians. All were considered of American nationality even though the blood mixture was considerable in many cases.

A study of the age distribution of these patients reveals nothing worthy of note. The age varied from three weeks for the youngest to eighty-one years of age for the oldest. Forty per cent were in the first three decades of life, thirty five per cent in the middle decades, and twenty-five per cent in the last three decades of life. The age of the patient, surprisingly enough, did not seem to have any direct relationship to the mortality.

SYMPTOMS AND SIGNS

The accompanying chart (Fig. 1) serves to emphasize the long known fact that a history of ab-

FIG. 1. RELATION OF SYMPTOMS TO ETIOLOGICAL AGENT PRODUCING THE OBSTRUCTION

SYMPTOMS	HERNIA		INTUSSUS-CEPTION		TUMORS		CONGEN-ITAL BANDS		VOLVULUS		FOREIGN BODY		ADHESIONS		Total %
	No. of Cases	%	No. of Cases	%	No. of Cases	%	No. of Cases	%	No. of Cases	%	No. of Cases	%	No. of Cases	%	
Pain	58	98	12	100	8	100	3	100	3	100	2	100	47	100	99
Nausea	49	82	2	16	8	100	1	33	2	66	2	100	46	96	82
Vomiting	43	72	11	91	7	87	3	100	2	66	2	100	43	91	83
Distension	6	10	6	50	7	87	2	66	2	66	2	100	43	91	51
Mass	55	93	10	83	3	37	0	—	1	33	0	—	7	15	57
Tenderness	55	93	5	41	0	—	0	—	1	33	0	—	5	10	50
No B.M.	0	—	1	8	1	12	0	—	0	—	0	—	9	19	8
Blood in Stool	0	—	10	83	0	—	0	—	0	—	0	—	0	—	7
Total Number Cases	59		12		8		3		3		2		47		—

dominal pain, intermittent and colicky in type, later followed by nausea, vomiting and distension, point to the diagnosis of acute intestinal obstruction. The finding of a tender, irreducible mass at a hernia orifice and/or abdominal tenderness, both add more weight to the diagnosis. The presence or absence of the sign of visible peristalsis and borborygmus were not recorded often enough to be evaluated in this review. The finding of blood in the stool was present in eighty-three per cent of the cases of intussusception and thus is a finding that must not be under evaluated in arriving at the diagnosis of intestinal obstruction due to intussusception. The history of no bowel movement since the onset of the

FIG. 2. TIME INTERVAL FROM ONSET OF SYMPTOMS BEFORE HOSPITAL ADMISSION AND FROM HOSPITAL ADMISSION TO TIME OF OPERATION

DIAGNOSIS	NUMBER OF CASES	Average Number Hours from Onset before Hospital Admission	Average Number hours from Hospital Admission to Time of Operation
Hernia	59	28 hours	4 hours
Intussusception	12	61 hours	5 hours
Tumors	8	127 hours	29 hours
Congenital Bands	3	186 hours	25 hours
Volvulus	3	24 hours	2 hours
Foreign Bodies	2	14 hours	7 hours
Adhesions	47	60 hours	37 hours
AVERAGE		71 hours	15 hours

symptoms seems to be of minor significance as judged by the fact that such a history was recorded in only eight per cent of the cases. A careful study of Fig. 1 will reveal that the symptomatology of acute intestinal obstruction is surprisingly uniform regardless of the underlying pathology producing the obstruction. The history of fecal vomiting which is so often mentioned in standard text books was conspicuous by its absence in this series of cases. It was encountered in only two cases, thus serving again to remind us that fecal vomiting is not necessary and certainly should not be required before the diagnosis of acute intestinal obstruction is established.

The average number of hours from onset of symptoms before admission into the hospital was found to be seventy-one hours. Fig. 2 shows the

average as regards the various etiological factors producing the obstruction. It was the opinion of the author before undertaking this study that there was a direct and easily demonstrable ratio between mortality and duration of disease before treatment was established; however, this study indicates that it is not the duration of the disease in itself that effects the mortality, but rather it is the state of progression of the pathology: i.e., to be more specific, the viability or nonviability of the intestine is the all important factor governing mortality. In some cases nonviability did not develop until three or four days from onset of symptoms, while in other cases nonviability developed as early as twelve hours after onset of symptoms. Nor does it seem possible to predict with certainty in which case nonviability will rapidly develop.

DIAGNOSIS

Fig. 3 is a tabulation of the various disease entities which were found to be the cause of the obstruction. As to be expected, obstruction due to strangulated hernia and intra abdominal adhesions comprised eighty per cent of the cases. Intussusception, tumors, volvulus, congenital bands and foreign bodies were found to be the etiological agent in the remaining twenty per cent of cases. Post operative multiple adhesions and/or bands following laparotomy for appendectomy and pelvic surgery produced over ninety per cent of the cases of obstruction due to adhesions. Obstruction following pelvic surgery was about one-third more frequent than following appendectomy.

PRE-OPERATIVE CARE

Pre-operative care in eighty per cent of the cases consisted of bed rest, sedation and observation. Parenteral fluids were received by but fourteen per cent of the patients before operation. None were transfused pre-operatively and continuous nasal suction for purpose of decompression was employed in but nine per cent of the cases. It is worthy of note that three cases received barium meals and six received barium enemas pre-operatively. Every patient subjected to a barium meal later died, while one-half of those receiving the barium enema later died. The author believes that this is more than just coincidental. The fact has long ago been established and the statement oft time repeated, that a bowel filled with barium adds greatly to any operative risk. Barium by mouth can only increase the obstruction and considerably increase the difficulty in obtaining satisfactory decompression, either by nasal tube or by the enterostomy tube inserted at the time of operation. Therefore, it would seem that barium by mouth is definitely contra-indicated in any case of suspected acute intestinal obstruction because of the

attending increase in operative risk should obstruction actually be present.

The use of the "flat film" of the abdomen as a preoperative measure to aid in establishing the diagnosis of intestinal obstruction and to aid in evaluating the necessity of immediate or delayed surgical intervention, seems not to have been generally employed. In less than five per cent of the cases was this aid employed. It should be reemphasized that an exporatory flat film of the abdomen will in most cases not only confirm the impression of acute intestinal obstruction, but will aid in the localization of the point of obstruction. In the conservative treatment of acute intestinal obstruction or in the period before surgery is undertaken, repeated "flat

ple and the treatment unequivocal; but in cases of obstruction due to adhesions, the decision to operate is a conclusion which can not always be readily formulated.

It is well at this point to call to attention the fact that every case of intestinal obstruction; more specifically, those due to multiple adhesions, does not require immediate surgery and that in all probability if proper non operative care is instituted early, surgery will be quite safely avoided in many instances. The fundamental principle of treatment of intestinal obstruction is to relieve the obstruction. Whether this is accomplished by nasal tube, enterostomy tube or by some more radical operative procedure is of no importance. The important fact to bear in mind is that the obstruction must be relieved before impairment of circulation to the involved segment of bowel has developed. In obstruction due to multiple adhesions there is in nearly one hundred per cent of cases a pre-existing organic partial obstruction which becomes complete because of edema produced at the site of the partial obstruction. This local edema is due to the associated distention and pounding of the physiological increase in peristalsis proximal to the point of obstruction. The increase in peristalsis is a physiological attempt to drive the contents of the intestinal lumen past the obstruction. In these cases if peristalsis is stopped and decompression successful, the local edema will promptly subside with resulting reestablishment of the continuity of the bowel and relief of the obstruction.

Another point worthy of consideration is the technical difficulty of really accomplishing anything but decompression at the time of operation in cases of obstruction due to multiple adhesions. The adhesions are so dense and so numerous that separation of all the adhesions (which will in all probability soon reform) without tearing the bowel wall is a technical impossibility in many cases. In this type of case the records show that often more harm than good was accomplished by the operation. Enterostomy is the main accomplishment of many of these operations. Therefore should we not ask ourselves, can not decompression be as completely attained and with much greater safety by the use of the continuous nasal suction? Consequently it would seem that a regimen of morphinization, decompression by nasal suction and hot stupes to the abdomen if desired, supplemented by parenteral fluids and blood transfusions when indicated is the procedure of choice in the management of these cases of intestinal obstruction due to multiple adhesions. However, it is to be remembered that procrastination and "hopeful waiting" can be as disastrous in cases of intestinal obstruction due to multiple adhesions as it proves

FIG. 3. TABULATION OF THE ETIOLOGICAL AGENT PRODUCING THE OBSTRUCTION

DIAGNOSIS		No. of Cases	Per Cent of Total
Hernia	Right indirect inguinal	25	
	Left indirect inguinal	14	
	Right direct inguinal	2	
	Left direct inguinal	2	
	Right femoral	8	
	Left femoral	3	
	Umbilical	3	
	Incisional	2	
TOTAL		59	44%
Intussusception		12	9%
Tumors	Ca. of Colon	3	
	Ca of Sigmoid	2	
	Intrinsic Ca. of Ileum	1	
	Fibroma of Ileum	1	
	Extrinsic Ca. of Pelvis	1	
TOTAL		8	6%
Congenital Bands	At Pylorus	1	
	At Ileum	2	
TOTAL		3	2%
VOLVULUS		3	2%
Foreign Body	Gallstone	1	
	Fecolith	1	
TOTAL		2	2%
Adhesions	Post Appendectomy	18	
	Post Pelvic Surgery	26	
	Post traumatic	2	
	Post Ruptured Diverticulum	1	
	TOTAL	47	35%

films" of the abdomen will give much information as to the progress of the obstruction.

The average number of hours elapsing between admission to the hospital and time of operation was fifteen hours. (Fig. 2). In cases of obstruction due to strangulated hernia the average was but four hours, while in cases due to adhesions it was thirty-two hours. This finding is to be expected since the diagnosis of a strangulated hernia is relatively sim-

to be in cases of strangulated hernia; therefore, the early establishment of a diagnosis based on the pathological state of the bowel is an all important decision which should be reached early. The question of surgery and opportune time for surgery depends more on the state of viability or nonviability of the bowel, than upon any other factor. If it can be decided that the viability of the bowel is endangered and is not being relieved by conservative measures then immediate surgery is unquestionably indicated.

PATHOLOGY FOUND AT OPERATION

In acute intestinal obstruction, the most important pathological finding is not the etiological agent producing the obstruction but is the state of viability or nonviability of the involved segment of bowel. In this series of cases the gut was found to be viable in 119 or eighty-nine per cent of the cases, and non viable in fifteen or eleven per cent of the cases. In the cases in which the intestine was viable there were but twenty-three deaths or a mortality rate of nineteen per cent. On the other hand, of the fifteen cases in which the intestine was not viable at the time of operation twelve of these died or a mortality rate of eighty per cent. It thus becomes self evident that any surgery must be undertaken before nonviability develops if we are to offer these patient's any reasonable expectancy of recovery.

OPERATIVE PROCEDURE

Fig. 4 shows that in the cases in which simple relief of the obstruction followed by closure or repair of the hernia was done, the mortality was but 11.4

FIG. 4. INFLUENCE OF OPERATIVE PROCEDURE ON MORTALITY

OPERATIVE PROCEDURE	No. of Cases	Deaths	Mortality
Release of obstruction followed by closure or repair of hernia if present.....	95	11	11.4%
Enterostomy	27	14	51%
Resection	12	10	83%

per cent. Cases in which enterostomy was used, the mortality was fifty-one per cent and in the twelve cases in which resection was employed there was an eighty-three per cent mortality. Careful study and evaluation of these statistics seems to point out several important conclusions. First, that the mortality rate is directly in proportion to the magnitude of the surgery and secondly that the pathological state of the intestine as regards its viability are the all important factors regarding the prognosis in any given case. That resection should be attended with an eighty-three per cent mortality seemed unnecessarily

high; however, it is not higher than usually reported in the literature. The reason for this high mortality is thought not to be due to faulty operative technique or any other factor attended with the operation itself but seems to be due in part at least, to insufficient activity during the post operative period. This will be discussed more fully in the next paragraph.

POST OPERATIVE CARE

Received routine care only	65%
Received parenteral fluids	35%
Received continuous nasal suction	27%
Received a blood transfusion	11%

It is found that sixty-five per cent of the cases studied in this series, the post operative treatment consisted only of bed rest, general nursing care, sedation and in some cases hot stupes to the abdomen. Parenteral fluid was given in thirty-five per cent of the cases, blood transfusion was used in only eleven per cent of the cases, and decompression was employed in but twenty-seven per cent of the cases. During the past five years the use of continuous nasal suction has become more frequent, but even at present it is not used in the majority of cases. In nearly one-half of the cases that suction was employed, it was used only as the last resort, that is, after marked distention had developed and had failed to respond to enema and stupe, then and then only was suction employed. Wangenstein¹⁰ was the first to point out and well establish the value of decompression in the treatment of acute intestinal obstruction. Since his earliest reports many other writers have confirmed and verified his findings until at the present time it should be an undisputed fact that decompression as accomplished by the continuous nasal suction or the Miller-Abbott tube is a post operative measure that should be used routinely in the care of any case of acute intestinal obstruction.

Blood transfusion has been known for many years to be a helpful agent in the treatment of many serious surgical diseases. Shock, sepsis, anemia, general toxemia and general exhaustion of body resources are all easily and effectively combated by the use of blood transfusion. Repeated small transfusions rather than a single large transfusion is probably preferable. The author believes that the routine post operative orders on every case of acute intestinal obstruction should involve the following principles:

- (1) Complete and continuous decompression.
 - (a) This may be accomplished either by the Wangenstein or the Miller-Abbott tube. Nasal suction may be used to advantage even though an enterostomy has been done.
 - (b) The entire system is to be cleaned and irrigated at least every three or four hours in order to insure its patency and efficiency.

(2) Diet: Water by mouth after the first twenty-four hours in sufficient amounts to alleviate thirst. This makes the patient more comfortable and as it is immediately siphoned from the stomach it aids in cleaning out the suction apparatus.

(3) Complete morphinization.

(a) In the average case this is accomplished by giving morphine gr. 1/6 every four hours as long as color is good and respirations are above sixteen.

(4) Hot stupes to the abdomen:

(a) Best accomplished by using a large (12 inch x 14 inch) warm flaxseed poultice. Warm boric or saline compresses may be used but require considerable more nursing care in order to maintain effectiveness. Whatever agent is used to maintain heat to the abdomen it should be light in weight.

(5) Parenteral fluids:

(a) Parenteral fluids should be given in sufficient quantity to insure a measured urinary output of at least 1500 c.c. daily.

(b) This can usually be accomplished by giving 1500 c.c. at five per cent glucose in N. saline "IV" twice daily and 1500 c.c. N. Saline sub "C" daily

(6) Blood transfusions:

(a) In an acutely ill patient repeated transfusions of whole citrated blood are of great aid.

(7) No enema, cathartics or drugs which stimulate peristalsis.

(a) No enema or cathartic of any kind should be given until many days after continuity of the bowel has been established. In some cases a low retention oil enema may be safely given after two or three days following the first spontaneous bowel movement.

(b) Pitressin and similar drugs are absolutely contra-indicated in the treatment of this disease as their action nullifies our every attempt to aid natural restoration of function to the intestine.

The more routine post operative use of parenteral fluid, morphinization, decompression by continuous nasal suction, and a blood transfusion when indicated, will greatly aid in the lowering of the mortality of this disease.

POST OPERATIVE FEBRILE REACTION

A study of the post operative febrile reaction was found to be most enlightening. Sixty per cent of the patients whose post operative febrile reaction reached 103 degrees or above at any time during their post operative course, died, while but two per cent of the cases with a maximum post operative elevation of temperature of 102 degrees or below, died. It thus may be concluded that the post operative febrile reaction may be used as a fairly accurate guide as to the ultimate prognosis in any given case.

The average number of days in the hospital was found to be sixteen days, with eleven days for cases of intussusception and seventeen days for cases of obstruction due to adhesions. It is doubtful that this is of any particular significance.

COMPLICATIONS

The following is an enumeration of the complications which developed post operatively in this series of patients. As to be expected, it represents the usual complications that may be expected to follow any major surgical procedure. The complication of peritonitis and shock were the only ones which seem to be more frequent than might be anticipated.

Shock, nine cases; Peritonitis, seven cases; Cardiac Failure, four cases; Bronchial pneumonia, four cases; Wound infection, three cases; Pulmonary embolism, two cases; Wound disruption, two cases; Subcutaneous abscess, two cases; Persistent fecal fistula, two cases; Aspiration pneumonia one case; Cerebral hemorrhage, one case; Thrombophlebitis of leg, one case; General sepsis, one case, and G-1 hemorrhage due to blood dyscrasia, one case.

MORTALITY

The gross mortality rate for this series was 26.1 per cent. Fig. 5 shows the mortality in respect to the various disease entities which produced the obstruction. The mortality from strangulated hernia

FIG. 5. MORTALITY

DIAGNOSIS	Number of Cases	Mortality
Congenital Bands	3	66%
Hernia	59	15%
Adhesions	47	30%
Tumors	8	62%
Volvulus	3	33%
Foreign Body	2	50%
Intussusception	12	25%
TOTAL	134	
GROSS MORTALITY		26%

FIG. 6. MORTALITY IN CASES OF OBSTRUCTION DUE TO A STRANGULATED HERNIA

TYPE OF HERNIA	Number of Cases	Mortality
Right indirect inguinal	25	12%
Left indirect inguinal	14	0%
Right direct inguinal	2	0%
Left direct inguinal	2	0%
Right Femoral	8	50%
Left Femoral	3	0%
Umbilical	3	33%
Incisional	2	50%

was the least while obstruction due to congenital bands was the highest. Fig. 6 illustrates the mortality due to strangulated hernia in respect to the type of hernia involved. As to be expected, inguinal hernia

has the lowest mortality rate. This is most probably due to the fact that the patient comes to the doctor earlier because he is aware of the presence of this hernia, thus enabling the establishment of an earlier diagnosis which ultimately leads to earlier surgical intervention. There is no forthcoming satisfactory explanation as to why right sided inguinal and femoral strangulated hernias have a higher mortality than those on the left.

SUMMARY

Acute intestinal obstruction remains a surgical disease of not infrequent occurrence, and is most often due to strangulation of a portion of the bowel in a hernia orifice, or is due to obstruction resulting from post operative bands and adhesions. The mortality from this disease is still high but it is believed that by earlier operation in every case in which viability of the involved segment of bowel is endangered, and by careful, constant energetic post operative care, we may rightfully expect to have an appreciable reduction in mortality. Routine post operative use of parenteral fluids, morphinization, decompression by nasal suction from the moment the operation is completed until the time the patient is passing flatus per rectum and has had a normal spontaneous bowel movement; and frequent resort to blood transfusions when indicated, will be the factors which will permit us to point with pride to a lower mortality rate from this disease.

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The path to the sanatorium must be made easy for the patient and his family. The social investigation should make this its primary function. It should not be a search for resources to be exhausted before the community assumes the cost. The great majority of cases come from families in the low income groups with little if any savings. Treatment is expensive. Insistence upon the use of all the family resources means impoverishment and they may become community charges for rent, food, and clothing. A family is wrecked. The prospect of this is one of the chief deterrents to early hospitalization and to continued stay until the disease is arrested. Edward S. Godfrey, M.D., New York State Commissioner of Health.

TESTS TO DETERMINE ALCOHOLIC INTOXICATION*

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In testing a driver for signs of intoxication the following essentials should be observed:

1. Obtain permission of the accused to examine him, before witnesses, explaining that he, the physician, may have to testify as to the results of the examination.
2. Inquire and examine for any disease process present.
3. Perform a neurological examination to discover any variation from normal in locomotion, stability, dexterity, and speed of reaction.
4. Make mental tests for orientation, memory, reaction time of thought, emotional disturbances.
5. Take specimens for chemical tests.
6. Keep careful written record of all findings.

Of the many neurological tests used for intoxication, experience has shown a few of great value, others almost useless. The pupillary reflexes are utterly meaningless unless to rule out tabes or other disease. The finger-to-nose test is seldom helpful. Even the Rhomberg test is often negative when other evidence removes all doubt. The first and most important test is the signature of the subject: When compared with his normal signature on his driver's license or other papers, it shows a high percentage of variation from normal. The next important observation is the manner in which the subject performs normal actions, such as buttoning his clothes. The ability to walk a straight line, turn and walk back on the same line, constitutes a good test. One of the best tests is the ability to stand on one foot.

The laboratory methods are the estimation of alcohol in the urine, blood, various body fluids, and in the expired air.

Of all of these the most useful examination which can be performed is the estimation of alcohol in the blood.

The simplest method of investigating the alcohol consumption of a subject is to estimate the alcohol in the breath: the results, however, have no constant definite relationship to the alcohol intake and concentration. If a person has had a drink of alcoholic liquor within a few minutes before the breath is tested or if he has been hiccoughing or vomiting, the result might be useless. Nevertheless, such tests

*This article was prepared by Dr. Willis H. McKean at the request of the Society Committee on Automobile Accidents and Fractures, with the thought in mind that it would be of interest to members and to other interested agencies.

are being accepted as evidence and are being utilized by some police departments in this country.

The estimation of alcohol in the urine was in years past, utilized widely in the laboratory investigation of the effect of alcohol. It had the advantage that the specimen was easily obtainable and the estimation was relatively simple. It seems that urinalysis for alcohol may be even less satisfactory as an accurate test for degree of drunkenness than the test for alcoholic content of the expired air, as there may be no way of determining when the alcohol present in the urine was excreted by the kidney. Moreover, the time that the sample was obtained may bear no relationship to the alcoholic brain concentration at the time of the accident. If urine is collected during the period of active alcohol absorption, naturally the blood and brain content will be higher than the urine alcohol, and if the sample is obtained when the blood alcohol level is falling there may be an increase in the urine alcohol over that of the blood and brain. There are also considerable conflicting data in the literature regarding the amount of alcohol which is excreted in the urine.

The discrepancies which may occur between the concentration of alcohol in the blood and in the urine can be avoided to some extent by making the test from the urine by the following procedure, which takes advantage of the close correlation of the concentration in blood and in urine taken at one-half hour intervals. The subject is requested to empty his bladder; the specimen is discarded or, if the concentration of alcohol is determined, it is taken as having only qualitative significance or is used in conjunction with the subsequent determination to judge whether the concentration in the blood is rising or falling. One-half hour later the individual is again requested to void. Even the small amount of urine collected is sufficient for the determination of the concentration of alcohol. The value obtained is divided by 1.3 and the result is taken as the concentration in the blood at the time the test was made.

According to some investigations the alcoholic content of the saliva corresponds with the blood alcohol concentration within three per cent. It has also been observed that the rate of increase in the content of alcohol in the saliva in some cases greatly exceeds the rate of increase in the blood. Furthermore saliva is known to contain varying quantities of oxidizable substances which in some instances may equal as much as twelve mg. of alcohol.

The estimation of the blood alcohol on the other hand, has been found to yield very valuable results, and the standard now most generally in favor is that a concentration of 0.05 per cent or below in the blood shall constitute conclusive evidence of sobriety, 0.15 per cent or above, evidence of intoxication;

and values between these extremes, probability of intoxication. Yet the blood alcohol content as a proof of degree of clinical intoxication may also be subject to serious objections. There is an individual sensitivity to alcohol which must be viewed in the same light as sensitivity to other agents such as tobacco and coffee. There are also variations in regard to individual tolerance. Results show that the maximum alcoholic concentration is higher in normal persons, that it reaches this maximum in from one and one-half to two hours remaining at this level for five hours and then gradually diminishes while in chronic users of alcohol it reaches its maximum more quickly, remains at this level for two hours, and then subsides much more quickly. Non-users rid themselves of all alcohol in seven and one-half hours, while heavy drinkers destroy it in about one-half the time. Certain figures tend to show that for a given degree of drunkenness there is a higher alcohol concentration in the blood of chronic drinkers than in that of non-drinkers. Thus, the clinical manifestations of intoxication in the average non-user are said to become noticeable at the blood alcohol level of 0.15 per cent, while in the habitual user they may not become manifest before an alcohol level of 0.2 to 0.25 per cent is reached. Thus it seems that even the blood test has drawbacks, as have the other tests mentioned.

Undoubtedly the most correct answer to the question of determining when a person is clinically and legally drunk is the spinal fluid-brain ratio test. In an examination of 6,000 brains for alcohol it was found that the effects produced on all persons, no matter what the previous alcoholic habits, were in direct proportion to the alcoholic content of the brain. The amount of alcohol consumed affected different people to different degrees, and that the power to oxidize alcohol rapidly was often developed to a marked degree in the habitual drinker, since he destroyed it more rapidly and hence it did not accumulate in the brain. These investigations showed, however, that when alcohol once reached the brain the effect was the same on both novice and seasoned drinker. It was demonstrated that a quantitative determination of the alcoholic content of the brain could be relied upon invariably to indicate the degree of clinical intoxication. In a normal brain the alcoholic content is less than 0.0025 per cent. In those subjects in which a history of alcoholic indulgence could be obtained, no physiological effect from the alcoholic indulgence was noted when the alcohol content in the brain was below 0.1 per cent. When the brain content ranged between 0.1 to 0.25 per cent, some physiologic disturbance was often observed, such as increased aggressiveness and more or less loss of sense of care, yet in none of these cases

was there any disturbance of equilibrium, which is the usual clinical index of intoxication. In the individuals examined where the brain content was above 0.25 per cent and from this on up to 0.40 per cent, definite disturbances of equilibrium were observed. The conclusion is that the degree to which any person is affected does not depend on the quantity of alcohol consumed, but on the amount of alcohol present in the brain at the time. There is a constant ratio between the spinal fluid alcohol content and the brain alcohol content. Studies have shown that the alcohol content of the spinal fluid could be used as an index of intoxication because of this constant ratio. All cases which showed 0.265 per cent or more of alcohol in the spinal fluid were clinically intoxicated.

The committee on tests for intoxication of the National Safety Congress in 1939 recommends that a level of alcohol in the blood above 0.15 per cent should be considered as definite evidence that the person is under the influence of alcohol from the standpoint of motor vehicle operation, but that in every case all available evidence of abnormal actions or condition should be obtained to permit presentation of a more convincing case. When the level of the alcohol in the blood is 0.15 per cent by weight or less the Committee recommends presecution, only when the circumstances and the results of physical examination confirm such evidence. When the level is below 0.05 per cent the Committee considers that the driver generally should not be prosecuted on such a charge.

The states of Indiana and Maine have passed laws which state that a alcohol concentration of 0.15 per cent or more in a person's blood is *prima facie* evidence that he is under the influence of intoxicating liquor sufficiently to lessen his driving ability within the meaning of the law.

Eye injuries in American industries are occurring at the rate of 1,000 every working day and ninety-eight per cent of them are wholly unnecessary, according to a study sponsored by the National Society for the Prevention of Blindness (Columbia University Press). It was found that about 1,000 workers lose sight of one eye and 100 or more the sight of both eyes in a year as a result of occupational hazards. Many more have damaged sight. It is pointed out that there is no need for the blinding of workers in American industry. The industrial accident and disease hazards affecting the eyes are now commonly known. Methods of eliminating these hazards or of protecting workers against them have been thoroughly demonstrated. Devices which provide protection against almost every type of eye accident are now available.—Science.

PREFRONTAL LOBOTOMY IN CERTAIN ABNORMAL MENTAL STATES

Ralph L. Drake, M.D.

James S. Hibbard, M.D.

Wichita, Kansas

Within the last six years there have been published a number of reports concerning the use of surgery in the alleviation of certain forms of abnormal mental states.

The immediate initiator of this movement, Egas Moniz¹, in 1935 attempted the interruption of frontal association fibers in twenty mental patients. He worked under the theory that in disorders of the psychofunctional type there is a rigid fixation of the cellular connecting groups in the frontal area which leads to the development of such psychic disturbances as anxiety, restlessness, exaggerated fears, apprehension, delusions of grandeur, hypochondriacal delusions, delusions of persecution, etc. In these twenty cases operated on by Moniz there were seven complete recoveries and seven in which marked improvement occurred. The best results were obtained in the agitated depressions but the failures were found to be in the chronic schizophrenic group.

In this country Freeman and Watts² have pioneered in this form of therapy. Their recently published monograph on the subject of Psychosurgery is most comprehensive, dealing with this relatively new procedure in all its aspects. The authors state that in the eighty cases they operated on approximately two-thirds are usefully employed, either earning a living or keeping house, while only six are confined to institutions.

TECHNIC OF PREFRONTAL LOBOTOMY

Since it is necessary to accurately separate the white matter of each frontal lobe in the plane of the coronal suture, Freeman & Watts' technic has been somewhat modified. X-ray films with markers are taken before operation and the coronal suture is accurately depicted on the scalp. The skin incision is made three cm. posterior to the lateral rim of the orbit and six cm. above the zygomatic arch. After the burr hole is made through the coronal suture and the dura is incised the anterior horn of the lateral ventricle is located by trial puncture with a brain cannula. In order to minimize the amount of trauma to the surrounding brain tissue the periosteal elevator used by Freeman & Watts has been ground down so that it cleaves the white matter with greater ease. At a point five cm. from the tip of the instrument a bore hole has been made to admit a short

steel rod. The ends of the steel rod are firmly held in place on the sides of the burr hole in the skull, and act as an axle as the handle of the instrument is rotated. Rotation of the instrument is guided by the skin markings. These refinements insure a very accurate method of separating the white matter of the frontal lobe.

TYPE OF CASE SUITABLE FOR OPERATION

From the results obtained in the 500 or so cases operated upon in this country and abroad, it may be stated that the most suitable patient is one who is suffering from a persistent and intense degree of anxiety or apprehension.

Now if we bear in mind the fact that the symptom, anxiety, may be present in almost any of the abnormal mental states, it is clear that this operation may be directed toward almost the entire gamut of mental disease. The following are the types of cases which have shown the best response to this operation—anxiety states, obsessive-compulsion reactions, agitated depressions, and agitated schizophrenia. The results have not been so good in chronic encephalitis, chronic alcoholism and chronic schizophrenia. It may be said that the more intelligent the patient, the better the response.

Freeman emphasizes the fact that in considering a candidate for this operation one must consider the degree of anxiety versus the possible post-operative defects and sequelae. Will the relief of this intense anxiety be welcome enough to the patient and family so that it will outweigh any of the possible complications?

EFFECTS OF OPERATION

Often immediately after the fibers are severed the patient loses his anxiety and nervous tension. He becomes quiet, relaxed and pliant.

Following the operation the face usually takes on a mask-like appearance. He becomes unresponsive and may go into a stupor. Vomiting accompanies or follows the operation. A plateau type of speech is quite common. Within a day or so there is a transitory disorientation of time and direction; there may be also various degrees of mental confusion and even hallucinations may be present for a short period of time. The patient loses interest in himself and becomes extroverted.

A most important feature is the fact that the intelligence, generally speaking, is unaffected. However, according to Freeman, there is often an apparent inability to foresee accurately the results of a series of planned acts as they relate to the individual himself. He becomes satisfied with something short of perfection.

Memory for recent events shows transitory dis-

turbance but memory for remote events remains intact.

REPORT OF A CASE

A married white woman, age fifty, came under observation in December, 1940. Her illness began in September, 1938, when her husband noticed that she was beginning to feel afraid that she could no longer do her housework as she should. This fear and anxiety continued and became accompanied by restlessness which progressed until December, 1940, when she developed episodes of panic. On several occasions she attempted to run away from home and at times threatened suicide. On another occasion she became panicky and kicked out the window panes of her home.

In January, 1941, she was given a course of insulin shock for a period of six weeks without benefit. Three months later she had metrazol therapy (six convulsive seizures) with slight decrease in restlessness. However, she gradually became worse and in April, 1942, metrazol was tried again without success.

Her anxiety became worse. She would constantly strike her forehead and cry, "Oh, can't you do something for this in here?" "I don't know what I am going to do. I would much rather be dead. I can't keep my house clean any more. I can't eat the right kind of food. Why, I never know what clothes to put on. I can't remember anything. I can't sit down one minute and read the paper."

She was well oriented and had no delusions or hallucinations. As she was definitely becoming worse it was decided to sever the frontal lobe fibers as a means of relieving this woman's anxiety.

On May 28, 1942, she was operated on at Wesley Hospital. Under local anaesthesia a prefrontal lobotomy was performed according to the procedure as outlined above. As soon as the fibers of the frontal lobes were severed she became less restless. When placed in bed she showed a mask-like expression of the face. She was quiet, relaxed, and while she presented no spontaneous act or speech she responded when spoken to. There was no marked shock at any time following the operation. The blood pressure which was normal before the operation showed no marked change during or after the operation. The day following the operation she developed hallucinations of her husband and sister being out in the hall. She was also confused as to directions. Otherwise she appeared well oriented, relaxed, responsive and showed no sign of restlessness or anxiety. The wrinkled furrows in her forehead were smoothed out and she gave no indication that she had been laboring under such anxiety. In fact, when the frontal lobe fibers were cut it was

as if a tightly stretched string had been suddenly severed and the ends immediately drooped. She has never spoken about her past condition at any time since the operation and has complained about nothing except that the head bandage was too tight. Since the operation she has become gradually more responsive and seems to be fitting into the regime in her home in the same way as before her illness. Interestingly enough, on the ninth day following the operation she laughed aloud for what was, according to her husband, the first time in four years. Not once has she talked concerning her past condition or her operation. At the present time, six weeks after the operation, she has completely recovered and, as far as her husband can tell, is the same as she was before her illness developed. She is now doing all of her own housework and has resumed her social obligations which she had been unable to carry on during her illness.

SUMMARY

1. Complete relief of symptoms in a case of anxiety neurosis by prefrontal lobotomy has been reported. The dramatic cessation of symptoms, unaffected by any other form of therapy, is sufficient reason for reporting this one case.

2. This form of therapy, which carries only about two per cent mortality, can bring about recovery in approximately two-thirds of selected cases.

3. This operation should not be performed indiscriminately in attempting to relieve psychic disorders. On the contrary, it should at present, at least, be reserved for those cases which have proved refractive to other forms of therapy and whose outlook is poor for ultimate recovery.

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The birth records which the doctor filled out for "his" babies in days gone by have now come into their own. These little documents, often completed in the middle of the night under trying conditions, have become the foundation structure upon which the United States government is building the entire national defense system. Proof that "his" babies are American citizens is what the doctor gave them when he made out their certificates, and the fact that the government goes to the physician's record for this evidence is, without exception, one of the highest compliments to be paid the medical profession. Here is another example of the unwavering confidence of the Government in the integrity of the American physician, and it compensates for those early morning sessions when making out the certificate seemed a senseless nuisance.—*Journal of the Iowa State Medical Society.*

INSULIN TREATMENT IN CHOREA*

A. C. Eitzen, M.D.

Hillsboro, Kansas

Insulin in smaller doses has recently given rather spectacular results in certain nervous disturbances. Using it for the depressed state in a case of ulcerative colitis I discovered that it had a favorable effect on the infection, causing a prompt remission of a long continued mild fever.

This induced me to try it on an especially stubborn case of chorea. The results in several cases have been remarkably good, much above my expectations and far better than anything else I have ever used. With a mild fever the temperature often drops to normal in a very few days after the beginning of the treatment. The nervousness and the mannerisms decrease as a rule within a week or two. Relapses have not been noted.

The mode of its action is not fully understood; but it is known to have a definite sedative effect and it may also stimulate metabolism thereby acting favorably on the encephalitis that is at the bottom of the disease.

Treatment is simple: six or eight units of plain insulin is given once daily at breakfast time or very soon after and followed in one or two hours by a glass of sweetened fruit juice. The dose is increased slowly to tolerance, avoiding more than mild reactions. It will usually range between twelve and twenty units. This is continued for two and one-half or three weeks; then a rest period of ten days is allowed. Another course or two may be given if it appears to be indicated. Hospitalization is not absolutely necessary.

It is my hope that this will stimulate further use and study of this treatment for chorea, especially by men who see more of the disease than I do, so that conclusions may properly be drawn.

*Presented at the 82nd Annual Session of The Kansas Medical Society, Wichita, May 12, 1942.

Doctors can be of great assistance in the "salvaging campaign" now being carried on throughout the country, by gathering up all their old discarded instruments and contributing them to the pool. For the most part these instruments are made from a high quality of steel and scrap steel, along with other scrap metals, which is one of the most needed things right now. As a matter of further interest, many of these instruments bear the imprint, "made in Japan." A good many years ago the country was flooded with Japan-made instruments, and it would be quite a gesture to return these to that country with our best compliments—in the form of war materials, of course.—*Journal of the Indiana State Medical Association.*

President's Page

To the Members of the Kansas Medical Society:

I am taking the opportunity at this time to keep all of the members of the State Society informed about a matter that is vital to our organization. Negotiations between Clarence Munns and the branches of the armed forces have reached the point that indicate that Clarence will soon be in the services of the armed forces for the duration. It will be with deep regret that we will lose Clarence's services at least for the present.

A recent emergency meeting of the Council was held to discuss this situation and several decisions were made; firstly, that we will hope to have Clarence back after the war and that his position will be open to him at that time if he wishes to return; and secondly, that The Kansas Medical Society must maintain an efficient central office and therefore, a new laymen executive secretary is to be obtained at once. Under the authorization of the Council, a special committee has been appointed to choose the new acting executive secretary.

It is my purpose in this communication to ask each member of the Society to comb his part of the State for likely candidates for this position and to ask such candidates to submit their application at once to any member of the committee. It is important that this be done as soon as possible. Please make this your individual responsibility and act at once. We must have the applications of well-qualified men as rapidly as possible, as the committee hopes to be able to make a selection within a few weeks.

The committee members, to anyone of whom applications may be sent, are as follows:

Dr. Warren Bernstorf, Winfield
Dr. W. P. Callahan, Wichita
Dr. F. R. Croson, Clay Center
Dr. J. L. Lattimore, Topeka
Dr. W. M. Mills, Topeka
Dr. C. C. Nesselrode, Kansas City, Kansas
Dr. Marion Trueheart, Sterling
Dr. H. N. Tihen, Wichita, Chairman

Kansas medicine, through effective organization, has developed an important and helpful place in the affairs of our State. It is imperative that we continue an effective central office to maintain this position.

Sincerely,

Henry N. Tihen, M. D.

President, The Kansas Medical Society.

EDITORIAL

ANTITETANIC SERUM: TECHNIC OF ADMINISTRATION

With increasing demands for the time of the physician, administration of antitetanic serum is one of many duties that can be safely delegated to the nurse in the hospital or office if a few simple rules are followed. Since the literature accompanying each package of the drug is voluminous and technical the following suggestions may be of practical value.

The site of injection should be in an extremity not injured. Then subsequent localized urticaria or regional lymphadenitis due to the serum may be easily differentiated from infection in a wound. The insertion of the needle should be low in the upper arm or thigh, not in the deltoid region or hip, so that a tourniquet can be placed above it if a severe immediate reaction should occur. A small needle should be used to deposit the serum in the subcutaneous fat for slow absorption.

As a test for a severe immediate reaction, two minims of serum may be injected. Without withdrawing the needle, the passing of two minutes should be measured with the second hand of a watch or clock. If the patient has not then developed dyspnea or wheezing as determined by observation rather than by asking questions, the remainder of the serum may be injected. The patient should remain under observation for another ten minutes.

Finally, if the serum was taken from a vial into a regular syringe, the needle, plunger, and barrel should be taken apart, rinsed, and allowed to stand for a time in cold water, thus preventing the "freezing" of the syringe that would result from sterilization if even a film of the serum remained.—Maurice A. Walker, M.D., Kansas City.

THE INTERNATIONALISM OF MEDICINE

There was a time when internationalism carried an unpleasant connotation. The internationalist was thought of as one without a Country or as one who would sell out his Country for an ideal or for gold. Today we are getting a truer concept of internationalism. The feeling is growing that one can have an intense love for his native land or the land of his adoption, be ready to live and die for it, and still believe that the advancement of civilization in the long run will depend upon international collabora-

tion. But before this idea can become effective many prejudices must be broken down.

We of medicine have a head start on the rest of mankind in true internationalism. Medicine, like all science, knows no National boundaries, nor does it recognize any taboo of color. In civilian practice a patient is a patient whether he be white, yellow, red, or black. It is our pride to bring him back to health regardless of his race or nationality. When we serve with the armed forces, wounded enemies receive the same medical attention as do our own casualties. Such an attitude toward stricken bodies is our God-given heritage and we are justly proud of it.

Unfortunately, we are prone to follow the rest of mankind when our interests swerve from medicine. We can read a scientific article by a Chinese physician, as an example, and give him due credit for his scientific research, but deep in our hearts we cannot rid ourselves of the thought that he belongs to an inferior race. Perhaps he, too, looks on all Occidentals as inferior.

The present terrible times through which the World is passing should prove a crucible to burn away all such prejudices. In the far East and the near East the yellow man, the black man, the Hindu, the Moslem Indian are fighting shoulder to shoulder with their white brothers for the cause of liberty and proving themselves the white man's equal. Every physician should learn this lesson and apply it for the future good of the entire world. Let the internationalism of medicine become that of the earth. F. C. S.—Philadelphia Medicine.

WAR WOUNDS OF THE MAJOR ARTERIES OF THE EXTREMITIES

Surgeons in the combat zones in this war are encountering a high incidence of serious wounds, many of them involving large arteries. The proper management of the severely wounded requires exception judgment and skill, especially when the large arteries of the extremities are involved, for one then has to consider the danger of the loss of limb as well as the danger of the loss of life. This concept is especially important during the periods of emergency treatment and subsequent transportation.

The emergency treatment of patients with wounds of large arteries consists essentially of controlling the hemorrhage and combating shock. Bleeding must be controlled promptly and efficiently, but, when possible, measures should be employed which do not interfere with the collateral circulation. There is a ten-

dency to consider the application of a tourniquet the procedure of choice for the control of bleeding from the large arteries of the extremities, but this is not as it should be. The tourniquet should be thought of as the final resort, to be used only when other measures have failed or are obviously inapplicable, for it obliterates all collateral channels and thereby jeopardizes the life of the limb. Bleeding from vessels exposed by the destruction of overlying tissues should be controlled by the application of ligatures both proximal and distal to the injured segment. When blood is escaping through a deep narrow channel, local compression will frequently suffice. If the bleeding is temporarily controlled by local compression, a tourniquet should be placed loosely around the extremity during transportation; it should not be tightened unless bleeding recurs. If it is necessary to control hemorrhage by the use of a tourniquet, a placard stating the time of its application should be attached to the patient's clothing. Patients so designated should be transported to a hospital and treated with a minimum of delay. If the tourniquet must be kept in place unduly long, it should be released for a few minutes each hour, the bleeding being temporarily controlled by direct pressure.

When patients with wounds of the major peripheral arteries reach a surgical hospital, they should be treated for shock, and the decision then made as to whether or not immediate operation is necessary. This decision may be difficult, but, in general, if bleeding does not recur and the circulation in the extremity is adequate, operation may be deferred. If operation is necessary, the injured tissues overlying the vessel should be excised and the artery exposed before the decision is made whether to repair or ligate it. Repair is especially indicated when the popliteal, common femoral, or carotid arteries are involved, because of the small number of collateral channels associated with these vessels. During World War I, the repair of injured arteries was not often feasible, but the postoperative administration of heparin has greatly improved the results from arterial suture.

If the character of the wound precludes successful repair, the injured segment of vessel should be resected and both ends ligated with heavy nonabsorbable material. The concomitant vein should also be ligated. Prompt measures must then be taken to preserve the integrity of the extremity, by increasing its blood supply, by decreasing the rate of metabolism, and by preventing infection. Measures to increase the blood supply are, in the order of their importance, sympathetic nerve block, placing the extremity at the proper level—usually somewhat below that of the left ventricle—the administration of vasodilator

drugs as nicotinic acid, papaverine, and whiskey, and the application of heat proximal to the site of occlusion. Local ischemia must be prevented if possible by frequent change of position and careful padding over bony prominences. The blood volume and content must be restored by transfusion, and if there is cyanosis the administration of a high concentration of oxygen is desirable. Occasionally the flow of blood through an extremity may be increased by the use of the so-called Pavex machine, which alternately produces positive and negative pressure. Unfortunately, this form of treatment is undesirable in the presence of extensive wounds and is absolutely contraindicated when infection is present. Furthermore, such a machine is of value only when the obstruction occurs at a sufficient distance from the trunk to permit proximal application of the cuff. The metabolic rate may be decreased by putting the extremity at complete rest and by temperature control. The optimum temperature cannot be stated definitely, but it is certain that heat should not be applied, and moderate cooling, to ordinary room temperature—seventy-two degrees F—is probably desirable. An attempt should be made to prevent infection by the local and systemic use of the sulfonamide drugs.

With the use of these measures, several of which have been introduced since World War I, it is to be expected that the untoward results of major vessel ligation will be appreciably decreased in the present war.—Virginia Medical Monthly.

WHAT DOES THE FUTURE HOLD?

In 1141 B.C. the Philistines defeated the Israelites and took the ark of the Lord to Ashdod, Gath and Ekron. The ark was infected with bubonic mice and a great and destructive epidemic of plague swept with terrifying fury through all the cities of Philistia.

At the siege of Naples in 1495 the French invaders contracted from the Spanish occupants of the town a disease now known as syphilis, said to have been introduced by the sailors of Columbus, a gift of the New World to the Old.

Cortez and the Spanish Conquistadors in 1520 carried smallpox with decimating effect to the inhabitants of Mexico. First settlers in North America brought tuberculosis to the Indians. Traders in the far North carried measles with fatal result to the Eskimos. Recently a new and virulent form of malaria appeared in Brazil, brought there in airplanes from the interior of Africa.

History has again ample opportunity to repeat itself. What new and strange diseases await us with the return of our expeditionary forces from the tropi-

cal countries? Will they bring us the flukes of China, the Delhi fevers of India, the dysenteries and amoebae of Malaya, the rickettsial, viral and parasitic diseases of Africa?

The American doctor could profitably be learning about the tropical diseases he will most certainly encounter, not only in the troops he will accompany to the tropics, but also in the soldiers who will be invalided back to this country. Patriotic citizens with the broom of political power in the hands of the ward stalwarts and the broom of domestic use in the hands of humblest housewife and the members of her family, had best get to work cleaning every yard, alley and dump in every city of our country. Cleanliness is next to godliness and an epidemic is an ungodly thing.—From *Virginia Medical Monthly*.

WAR SHORTAGE OF DRUGS AND MEDICAL APPLIANCES

The subcommittee of the Committee on Public Health Relations of The New York Academy of Medicine has done a noteworthy piece of work in surveying, with the help of representatives of leading drug manufacturers and distributors and from several divisions of the government, forthcoming shortages in essential medical materials. The medical profession has read of the shortages in the essential materials for industry, the priorities which have now been established in many lines, but it has more or less assumed that in some way the basic materials used in the practice of medicine would continue to be available.

However, the supply of drugs from many foreign countries has been drastically curtailed or completely shut off. Lack of shipping facilities has made belladonna and colchicum practically unavailable. Drug substances used in the manufacture of war equipment—alcohol, phenol, glycerine, magnesium, mercury and zinc—are becoming less and less obtainable.

The Army and Navy are taking for immediate use, and storing up against possible future needs, vast supplies of quinine, morphine, sulfa drugs, bandages, surgical instruments, and the like. Lend-Lease requirements are also taking a heavy toll. Materials in this category are being sent to Britain, Australia, India, South Africa, China, Free France, Soviet Republics, and Central and South American Republics. There are priority rulings on materials used in packaging—tin plate and lead, and it is probable that the use of paper cartons and wooden packing cases will shortly be curtailed.

Transportation is developing acute shortages and

deliveries are being accomplished under greater and greater difficulties. The United States Pharmacopoeia has relaxed storage requirements for some drugs such as ergot and made official substitutes for codliver oil.

The report of The New York Academy of Medicine urges that hospitals and surgeons exercise the utmost economy in the employment of operating-room and other materials and apparatus; that in prescription work tablets and capsules be substituted for elixirs, tinctures, fluid extracts, and preparations containing syrups and glycerine. It is also recommended that every step, including subsidy, be taken to favor the production in this country of certain vegetable drugs hitherto imported. The Academy very sensibly urges that steps be taken to produce in this country previously imported or manufactured items and that official drugs and their preparations together with certain newer chemical drugs be given priority over unofficial and proprietary preparations. —New York State Journal of Medicine.

THE DOCTOR AS A PATIENT

When the physician himself becomes a patient he is apt at the same time to become a better physician. He is forced, for the time being at least, to look at illness subjectively rather than objectively. A group of symptoms, which in someone else he would view with intellectual calm, now evokes emotional reactions which vary in intensity from mild annoyance to the deepest anxiety. Unless the physician is acutely sensitive to this emotional response to disease on the part of his patients, he will not fulfill his entire obligation to them. Since an illness of his own is very apt to sharpen his awareness of the patient's point of view, it makes him a better doctor. Unfortunately, in a sense, the subjective emotions of illness do not last long, and the physician soon forgets the fears and worries which beset the ill.

A re-statement of this familiar and somewhat moth-eaten admonition would be pointless without the following practical suggestion: Read in the *Journal of the Mount Sinai Hospital of New York* (Jan.-Feb. 1942) an article on page 1079 by the late Dr. Soma Weiss, entitled, "Self Observations and Psychologic Reactions of Medical Student A. S. R. to the Onset and Symptoms of Sub-acute Bacterial Endocarditis." Whenever you detect in yourself a tendency to become somewhat calloused or "case-hardened," re-read the article. If it does not make you a more sympathetic and understanding physician, then you have missed your proper calling.—*Philadelphia Medicine*.

TUBERCULOSIS CONTROL

WORK TOLERANCE FOLLOWING TUBERCULOSIS

The original purpose of a sanatorium was largely the segregation of a patient with an infectious disease dangerous to his neighbors. Enough bacillary cases were cured or arrested through rest, fresh air, proper food, to encourage the development of sanatoria for the "early case" which held good hope of cure. Refined methods of diagnosis soon showed that the minimal case was a rarity and that prolonged bed rest was nearly always essential. This principle is still valid even with the introduction of collapse therapy as an effective form of treatment. The criticism arose that we were making healthy loafers out of sick workers and it was too often justified.

Thereupon, occupational therapy crept in to relieve the tedium of enforced idleness and then followed a more constructive approach known by the awkward name of rehabilitation which included education and vocational training. Treating the disease while the patient is an invalid in the hospital is no longer considered sufficient. Adequate care involves preparation for maximum social and economic adjustment when the disease is arrested or apparently cured.

This duty develops upon the sanatorium. "As soon as an estimate of the disease processes is arrived at and the course of treatment decided upon, a beginning can be made in education. An early analysis of the patient's educational and occupational background, of his interests and aptitudes can be made and a course of training outlined. This can be made to synchronize with his medical treatment and other activities permitted, and it can be carried throughout the full length of stay of the patient in the sanatorium. As well, there are many of the facilities of the sanatorium which can be used for both training and physical rehabilitation. All the program requires is the coordination and cooperation of the various staffs of the hospital and occupational therapists who are willing to accept adult education as being a branch of occupational therapy.

"The appraisal of the ability of the individual to do some line of work begins with securing past-work history and continues throughout the period of training. Also the counseling of the patient and testing for special aptitudes by trained observers aids in appraising. It not only helps evaluation but it gives direction to effort, eliminating much time

wasted by trial and error methods, and is most useful in creating interest and cooperation in patients."

Appraising the physical stamina of the patient to stand the strain of normal life is difficult. We have no clinical or mechanical tests to use as reliable measures of work tolerance. We cannot say just how many foot pounds of muscular energy this individual can safely expend, nor how much mental strain he can endure without reactivating his disease. Furthermore, our knowledge of just how much energy a given job requires is but vaguely known. Job analyses are usually made on the basis of speed rather than foot pounds of energy required.

Our present recourse, then, is the study of the patient as an individual during his stay in the sanatorium. Close observation will give us an appraisal of his inherent resistance to breakdown from physical effort, nervous upsets, or even intercurrent infection. With the knowledge thus gained the trial method of graduated exercise should be undertaken with careful watching. "Signs and symptoms of intoxication indicate over-exertion and need for return to rest therapy. Rise in temperature, increase in pulse rate, fatigue and loss of weight, sputum changes in quantity and content, changes in sedimentation rate and blood count and later increase in pathology as shown by x-ray, suggest reactivation.

"In order to establish with more surety that a patient can withstand sustained efforts, a period of physical rehabilitation should be followed before discharge of the patient. Before it can be certain that the patient can lead a normal life and stand up to ordinary work conditions, sanatorium routine and cure hours should be broken. One of the hardest things for a patient is to discontinue the mid-day rest period. If he can be put on a full work schedule of forty hours a week for a few months before discharge and is able to play after work without undue fatigue, he should be able to do the same outside. This can be readily done in a sanatorium where there is a constant need for help and often to the advantage of the sanatorium."

In addition to the graduated exercise, test inferences may be drawn from x-ray studies of the characteristics of the disease during treatment, such as a tendency toward fibrosis, rapidity of healing and such evidences of good resistance. On the other hand, very extensive disease with reduced vital capacity, distortion of chest structures and possible cardiac embarrassment are obvious causes of low work tolerance.

In connection with its rehabilitation program, for over ten years Niagara Sanatorium (New York) has given close study to the problem of determining work tolerance. While only about half the pati-

ents are considered to afford hope of effective vocational rehabilitation, careful study is made of every case since whatever occupational therapy is possible is employed routinely. Patients have been given aptitude and personality tests by personnel from the National Tuberculosis Association and the State Rehabilitation Department has made provision for the completion of courses in a number of cases.

Only modest claims are made for the results thus far achieved. "It is true that the death rate in the sanatorium has remained unchanged, but the readmission rate has decreased, as have deaths of patients after discharge. This decrease in readmissions counterbalances the increased initial length of stay. Of fifteen patients who have been aided by state rehabilitation, only one has since broken down and this was the result of lobar pneumonia in a patient with a complete thoracoplasty. As well as the evident individual results we have obtained, the morale of the entire population has improved. Few patients leave now because of boredom. Also, it has given us an employment agency, not only for temporary help but for permanent employees who have been tried and their ability proved. Some of our most valuable employees are ex-patients, trained in the peculiarities of our set-up and most valuable in that they carry with them the patients' viewpoint and an understanding of patients' trials and tribulations.

"To summarize, a rehabilitation program can be developed in a small sanatorium with benefit to patients individually and collectively and with advantages to the sanatorium. Tolerance for selective work can be built up in patients, but the evaluation like that for determining disease status, being dependent upon personal judgment of the significance of the individual's reactions, is only approximate. The program can be carried on at no great cost to the community and over a period of time the community, as a whole, will be repaid many times over."—From Tuberculosis Abstracts, August 1942. The Need for Developing Work Tolerance Following Pulmonary Tuberculosis, A.M. Aitken, M.D. Paper given at annual meeting of National Tuberculosis Assn., Phila., Penna. May 6-9, 1942.

The Annals of Surgery, the oldest surgical journal in the English language, is now to be translated in Spanish and appear monthly. This results from the negotiations of the Coordinator of Inter-American Affairs and Director of the Hispanic Foundation, together with one of the oldest and most respected publishing firms in Buenos Aires, Guillermo Kraft Company. No better symbolic demonstration can be given of the sincere willingness to develop permanent intellectual fraternization between surgeons of the two countries.

NEWS NOTES

ASSISTANT LAY SECRETARY

In accordance with a resolution adopted by the House of Delegates, the Council at a meeting held on August 9 made arrangements to employ an assistant lay executive secretary in the Society central office.

A committee consisting of: Dr. F. L. Loveland, Chairman, Dr. Henry N. Tihen, Dr. J. L. Lattimore, and Dr. W. M. Mills was appointed by the Council to consider applicants for the position.

The Committee recently announced that it had employed Miss Jane Skinner of Stockton.

Miss Skinner, who has been an employee of the State Business Manager's office during the past three years, commenced her work for the Society on August 17.

COMMITTEE CHAIRMEN

Dr. Henry N. Tihen, President, has announced the appointment of Dr. Robert G. Klein of Dodge City to succeed Dr. Robert Sohlberg of McPherson, as Chairman of the Society Committee on Public Health and Education and the appointment of Dr. J. E. Henshall of Osborne to succeed Dr. Lee Leger of Kansas City, as Chairman of the Society Committee on Location and Medical Distribution.

Dr. Sohlberg and Dr. Leger recently entered the military service and thus resigned their positions in the above capacity.

MILITARY SERVICE

The Kansas Medical Officers Recruiting Board has furnished the following information as of August 21 in regard to the applications for commissions in the Medical Corps of the Army which have been made to that Board since it was established in the State on May 18:

Number of officers commissioned by the board.....	80
Number of applications forwarded for final action by the Surgeon General	39
Number of applications ready for commissioning.....	7
Number of applications rejected physically	40
Number of applications pending	27
Number of applications on file "Not Available" by Procurement and Assignment	47

Total applications received240

The below listed physicians have received commissions from that Board in addition to the ones which were listed in the June issue of the Journal:

John Aldis, Emporia	First Lieutenant
Karl A. Carlin, Eureka	First Lieutenant
Raymond A. Schwegler, Lawrence	Captain
Harry J. Bowen, Jr., Topeka	First Lieutenant
Emmerich Schulte, Kansas City, Kans.	Captain
Harry M. Roach, Lawrence	First Lieutenant
Ernest E. Harvey, Salina	First Lieutenant
Robert M. Brian, El Dorado	Captain
Donald E. Bux, Columbus	First Lieutenant
Carl T. Buehler, Halstead	First Lieutenant
Billens C. Gradinger, Halstead	First Lieutenant
Charles T. Sills, Newton	First Lieutenant
Carroll W. Armstrong, Salina	First Lieutenant

George Mandeville, Dodge City, Kans.	Captain
Abraham Sophian, Jr., Kansas City, Kan.	First Lieutenant
Leslie J. Brethour, Junction City	First Lieutenant
Joseph G. Evans, Kansas City, Kan.	First Lieutenant
Lloyd G. Schwartz, Topeka	First Lieutenant
Edmer Beebe, Olathe	Captain
Ralph M. Wyatt, Hiawatha	First Lieutenant
Samuel L. Stout, Wichita	First Lieutenant
Charles T. Frey, Wichita	First Lieutenant
William G. Weston, Arkansas City	Captain
Paul B. Young, Wichita	First Lieutenant
Harry O. Anderson, Wichita	First Lieutenant
Richard E. Beldridge, Kingman	First Lieutenant
Raymond C. Clapp, Wichita	First Lieutenant
George F. Gsell, Wichita	Captain
Frederick L. Ford, Topeka	First Lieutenant
Leo C. Murray, El Dorado	Captain
H. Lester Reed, Kansas City, Kan.	First Lieutenant
Mark L. Stone, Topeka	First Lieutenant
Morgan L. Mollohan, Arcadia	First Lieutenant
Charles R. Kempthorne, Manhattan	Captain
Adelbert S. Reece, Gardner	Captain
Schubert D. Henry, Kansas City, Kan.	Captain
Frank A. Moorehead, Neodesha	First Lieutenant
Robert Sohlberg, Jr., McPherson	Captain
Kenneth W. Carbaugh, Mission	Captain
Paul E. Davis, Larned	Captain
Edward J. Grosdidier, Kansas City, Kan.	Captain
George R. Maser, Overland Park	First Lieutenant
John H. Luke, Kansas City	Captain
Alfred J. Horejsi, Ellsworth	First Lieutenant
Wayne O. Wallace, Atchison	First Lieutenant
Stephen S. Ellis, Coffeyville	First Lieutenant
William C. Fairbrother, Madison	Captain
Marshall E. Christmann, Pratt	First Lieutenant
Samuel E. Kerr, Emporia	First Lieutenant
Chester L. Young, Kansas City	First Lieutenant
William Brown, Paola	Captain
Clyde W. Miller, Wichita	First Lieutenant
Cecil D. Baird, Eureka	Captain
Clovis W. Bowen, Valley Falls	First Lieutenant
Joseph H. Johnson, El Dorado	Captain

A considerable number of other Kansas physicians have received Army and Navy commissions through the medium of direct applications to Washington. These are not included in the above lists.

The medical requirements of the Army and the Navy are still very great and thus the government is particularly anxious to receive applications from all physicians less than forty-six years of age who can possibly be spared from civilian and industrial activities.

COUNCIL MEETING

A meeting of the Council was held in Topeka on August 9. Members in attendance were: Dr. Henry N. Tihen of Wichita, Dr. F. R. Croson of Clay Center, Dr. R. R. Cave of Manhattan, Dr. Herbert Atkins of Pratt, Dr. C. D. Blake of Hays, Dr. W. P. Callahan of Wichita, Dr. O. W. Davidson of Kansas City, Dr. L. D. Johnson of Chanute, Dr. J. H. A. Peck of St. Francis, Dr. J. W. Randell of Marysville and Dr. Philip W. Morgan of Emporia. Others present were: Dr. Marion Trueheart of Sterling, Dr. F. L. Loveland of Topeka, Dr. C. C. Nesselrode of Kansas City, Dr. W. M. Mills of Topeka and Clarence Munns.

The following are excerpts of the minutes of the meeting:

"Dr. Loveland presented a report on the progress being made in conjunction with the Kansas Procurement and Assignment Service program. Several questions were asked and several matters were discussed in that connection.

Dr. Tihen stated that there is a possibility that Clarence Munns may enter the military service and that he felt, therefore, that a meeting of the Council should be held to discuss the plans to be made concerning the central office in the event that should occur. He stated, also, that this meeting had been called for that purpose and that members of the previous executive secretary committee of the Society had been asked to attend and take part in the discussion. Clarence Munns explained several matters pertaining to his application for military service and stated that he felt the Society should accept his resignation in the event he is accepted, and should proceed to employ new and permanent personnel in the office. Following a discussion of this matter a motion was made by Dr. Nesselrode, seconded and carried, that the President be empowered to appoint a committee, of which he should be a member, to select and employ a man as acting executive secretary. On a motion made by Dr. Morgan, seconded and carried, it was agreed that the position of executive secretary should be offered to Clarence Munns when he returns from military duty.

Dr. Tihen then discussed the matter of an assistant executive secretary as was recommended and adopted by the House of Delegates at its 1941 meeting. It was moved by Dr. Peck, seconded and carried, that Dr. Tihen, Dr. Lattimore, Dr. Mills and Dr. Loveland be designated as a committee to interview and employ a woman as assistant secretary."

An executive committee consisting of Dr. Henry Tihen as chairman, Dr. W. P. Callahan, Dr. F. R. Croson, Dr. J. C. Lattimore, Dr. W. M. Mills, Dr. C. C. Nesselrode and Dr. Marion Trueheart was appointed to accept applications and to employ an acting lay executive secretary in the event the above needs should arise. The committee forwarded a bulletin to the county medical societies on August 12 requesting that members forward the names of lay persons who might be interested in applying for the position.

Announcements concerning the action taken by the other committee in regard to the employment of an assistant lay secretary is contained elsewhere in this issue.

NEW COMMITTEE

Dr. Henry N. Tihen, President, has appointed the following members to serve as an Advisory Committee to the Kansas Medical Assistants Society: Dr. H. L. Lattimore of Topeka as Chairman, Dr. Irl Hempstid of Hutchinson, Dr. Clyde O. Meredith of Emporia, Dr. C. D. Blake of Hays, Dr. L. B. Spake of Kansas City, and Dr. A. W. Fegtley of Wichita.

The committee will be called the Committee on Medical Assistants.

ACCIDENTAL DEATHS

The Kansas State Board of Health recently issued a pamphlet entitled "Kansas Accidental Death Report for 1941." The report contains a summary of 1427 accidental deaths which occurred in the state during the year and of which 537 were motor vehicle deaths, 190 public deaths, 517 home deaths and 183 occupational deaths.

This is the tenth consecutive year that the Board of Health has published such a report. Accidents, according to the report have dropped, in 1941, from their usual fifth to sixth place as the cause of death in Kansas.

Other information in the report included, death of age groups, accident as cause of death, death according to sex groupings, death on days and months, seasonal hazards as death causes, types of injury and other forms of charts, data and graphs.

DIATHERMY REGISTRATION

The following information in regard to registration of diathermy equipment was published in the July 20 issue of the publication "Broadcasts":

"Diathermy Count Not Yet Complete—Expressing concern over the rate of registration of diathermy apparatus, following an order of May 16 (BROADCASTING, May 18), FCC Chairman James Lawrence Fly at his press conference last Monday revealed that 67,601 applications for registration had been made. However, he said that "we have the impression that there is an additional number about the country" and voiced the hope they will be registered promptly in accordance with the order.

Mr. Fly declared the FCC's concern over the diathermy registration arose from interference that can be caused by such apparatus and because it can be adapted for transmitting purposes. However, he cautioned that his observations should not be construed to mean that there had been "cases established" where machines had been used improperly.

In answer to a question, he declared that some years ago a modified diathermy machine had been used by the FCC in an experiment and that its signal, being sent from Massachusetts, had been picked up by an FCC field office in San Diego.

The original order had required machines to be registered before June 8. However, this was later amended to require registration each 5th of the month of all dealers' business in diathermy apparatus. Mr. Fly's offhand guess was that the 67,601 diathermy machines now registered represented about two-thirds of those in use."

All physicians owning diathermy apparatus who have not yet registered should communicate at once with the Kansas City office of Federal Communications Commission, 809 United States Courthouse, Kansas City, Missouri.

PROCUREMENT AND ASSIGNMENT MEETING

Lt. Col. Sam F. Seeley, Executive Officer of the Procurement and Assignment Service of Washington, D. C., was the guest speaker at a luncheon meeting of the Jackson County Medical Society of Missouri and the Wyandotte County Medical Society, which was held in Kansas City, Missouri on July 28.

Lt. Col. Seeley discussed the "Procurement and Assignment Service for Physicians".

INDUSTRIAL DIVISION

The Kansas State Board of Health announced on August 24 the creation of a new division of Industrial Hygiene, which will provide consultant service for industries of the

State. Dr. R. M. Heilman of the United States Public Health Service has been selected to head the new division. Dr. Heilman was graduated from the University of Nebraska Medical School in 1938 and formerly practiced in Lyon, Nebraska.

The Kansas Industrial Hygiene Service has, since its inception five years ago, been a part of the Sanitary Engineering Section of the Kansas State Board of Health, at Lawrence. Quarters for the new unit will be provided for all technical and clerical personnel of the division at Topeka, in order that they may work closely with the directors of the divisions of Local Health Service, Venereal Disease Control and Tuberculosis Control.

EMERGENCY MEDICAL SERVICE IN KANSAS

The Kansas State Board of Health, under the supervision of Dr. F. C. Beelman, Secretary, recently published a survey of the medical facilities of the State. For use in the defense program, material has been compiled on hospitals, bed facilities, empty buildings available for emergency bed space, water and sewerage systems, Red Cross, pharmacists and medical and nursing personnel, available throughout the Kansas.

The 1941 census lists the population of Kansas as 1,757,196. Physicians registered in Kansas in 1940 were 1,901 or 1.08 per 1000 population. Nurses registered in the State in 1941 and actively engaged in nursing were 2,250 or 1.28 per 1000 population. The total number of Kansas nurses registered as active and inactive in 1941 are 3,237. There are eleven full time health officers and 128 part time in Kansas, with 185 public health nurses.

Kansas has 130 hospitals, 122 of which are accredited. The total bed capacity is 15,739 or 8.9 beds per 1000, and a total average daily census of 11,873. In data on hospitals the county population, names of the hospitals and the superintendent in attendance is given, and the year in which the hospital was established.

Maps of the Kansas Pharmaceutical Captain plan of Organization for the State as of May are printed in the bulletin.

BLUE CROSS MAKES PROGRESS

The Kansas Blue Cross Hospital Plan ended its first month of operation with a total of 1,858 subscribers, representing thirty-seven employee groups, according to Mr. Sam J. Barham, Executive Director of the Kansas Group Hospital Service Association, Inc. The enrollment on August 1 represented an increase of approximately 350 per cent over July 1, when the plan began operation.



BUY
WAR
BONDS
AND
STAMPS

Thirty-two hospitals in twenty-five cities and towns are enrolled. Though much of the enrollment to date has been in Topeka, where thirty-two of the thirty-seven employee groups are located, the work is being extended into other parts of the State as fast as the limited personnel of the office permits. In Goodland, Wellington and Caldwell, the physicians and hospital personnel, with the assistance of the civic organizations, have conducted much of their own enrollment campaign.

Miss Frances Hurd, enrollment representative, has been stationed at Hutchinson for the past two weeks, conducting a membership campaign under the assistance of the Rotary club of that city.

More state-wide interest is now being shown, with considerable publicity appearing, and it is believed that the central office in the Crawford Building, in Topeka can expect a great demand for information concerning the plan.

Hospitals registered as members as of August 1 are as follows: Asbury Protestant of Salina, Axtell Christian and Bethel Beacons of Newton, Boothroy Memorial of Goodland, Caldwell of Caldwell, Charlotte Murray Memorial of Dodge City, Cushing Memorial of Leavenworth, Grace of Hutchinson, Hadley Memorial of Hays, Hatcher of Wellington, Horton of Horton, Johnson of Chanute, Mercy of Fort Scott, Randell of Marysville, Ransom of Ottawa. St. Anthony Murdock Memorial of Sabetha, St. Anthony's of Hays, St. Catherine's of Garden City, St. Elizabeth's Mercy of Hutchinson, St. Francis of Topeka, St. John's of Leavenworth, St. John's of Salina, St. Joseph's of Concordia, St. Mary's of Emporia, St. Mary's of Manhattan, St. Rose of Great Bend, Sterling of Sterling, Stormont of Topeka, St. Thomas of Colby, William Newton Memorial of Winfield, Christ's of Topeka, and Dickinson County Memorial of Abilene.

HEALTH DEPARTMENT

An agreement was recently made between the officials of the City of Topeka and those of Shawnee County, wherein a combined health department would be established to serve the needs of the city and the county.

Previously separate health departments, with separate personnel and facilities have been maintained. It is believed that the new plan will provide a more efficient and economic organization. The new health department will be under the direction of Dr. D. D. Carr, as health officer. Members of the board which will supervise the department are as follows: Dr. F. C. Taggart, Chairman, Dr. Paul E. Belknap, Dr. M. B. Miller, Dr. W. C. Menninger, Dr. C. F. Smith, Mr. Frank Long, Mr. Perry Pitcher, Mr. Walter Stumbo, Mr. Strong Hindman, Mr. Harry Snyder, and Mr. C. E. Betts.

As heads of the various departments the following have been appointed: Mr. Tom Powell as Chief of the Sanitary Department; Leslie Rowles, D.V.M., as Chief of the Milk Department; Mr. Ernest Lamb as Chief of the Food Inspection Department, Mr. Emil Freienmuth in charge of the Laboratory and Miss Rose Werner acting as nursing supervisor.

SELECTIVE SERVICE

The following bulletin was recently forwarded to the secretaries of the county medical societies and the official representatives in regard to medical examiners for Selective Service boards:

"As you know, Kansas Selective Service Headquarters has followed a policy, since the inception of its program, of requiring the approval of county medical societies in regard to the appointment of medical examiners for local Selective Service boards.

Their procedure in this regard has been as follows: to write the Society central office when a vacancy occurs and to request that office to communicate with the county medical society of the place of the vacancy, for suggestion and approval of an appointee. Upon receipt of this information, Kansas State Selective Service Headquarters then forwards the name recommended, to Washington for certain necessary approval.

The correspondence incidental to this procedure frequently requires considerable delay and this sometimes occasions difficulties for local boards. Hence, in an effort to eliminate this problem, the following possibility has been discussed which we would like to submit for your consideration:

1. That the physicians in each county in the State (regardless of whether or not it has a separate county medical society), prepare a list of members who are willing to serve as Selective Service medical examiners.

2. That this list consist of at least three members, in the event that many members are available in the county, and that the list be arranged numerically in the order in which the members are to serve.

3. That these names be forwarded to the Society central office; that the Society central office forward the list received to the Kansas State Selective Service Headquarters; and that when a vacancy arises the Kansas Selective Service Headquarters may consult the list for that county and may select the proper numerical name from that county's list and forward it to Washington for approval to fill the vacancy.

4. That when the numerical list for a particular county is exhausted, this office will be requested to obtain a new list of nominees from that county.

5. Likewise, that when a particular physician feels that he has served as a medical examiner for a considerable length of time and that he would like to have the work rotated to another physician, he can request the Kansas State Selective Service Headquarters to release him from his duties and to select another appointee from the list.

It seems to us that this plan would be advantageous in several ways, and thus we thought your society might be willing to take part in it. If it does desire to do so, we would greatly appreciate your completing and returning the enclosed questionnaire for this purpose."

BLIND PROGRAM

Dr. H. L. Kirkpatrick, Supervising Ophthalmologist for the Kansas State Board of Social Welfare, recently issued the following report pertaining to examination and treatment furnished under the Kansas blind program as of July 1, 1942:

AID TO THE BLIND

	June	1942	'38 to Date
New Examinations—Eligible	23	127	2602
Ineligible	18	86	1911
Total	41	213	4513

THE Kansas Industrial Development Commission has launched a three-phased drive to promote the welfare of the existing Kansas industries and encourage a new development, especially in the field of aeronautics. The program includes the assembling of a machine tool inventory, an analysis of Kansas' present and prospective air facilities, and the assembling and publishing of an up-to-date Buyers' Guide.

The Commission and the Kansas State Planning Board compiled a Buyers' Guide in 1941 and the revision of this Guide, now under way, is in response to a need evidenced by inquiries from military officials and purchasing agents.

"The Commission feels," said James F. Price, secretary-director, "that when a purchasing agent indicates a desire to buy a Kansas-made product the Commission should be in a position to tell him where and from whom the product can be obtained. The information found in the Buyers' Guide will greatly assist Kansans to discover the great variety of products that can be obtained from Kansas manufacturers. With transportation facilities at a premium and with the growing scarcity of consumer goods, it will be to everyone's advantage to learn what can be purchased close at home."

The machine tool inventory also is not a new project with the Commission, as Commission representatives have been assisting in the placing of orders in Kansas machine shops since the beginning of the defense effort. This information is being brought up-to-date and catalogued at this time to be presented to Mr. Lou Holland, head of the Smaller War Plants Corporation in Washington, D. C. The Commission has repeatedly shown that proper presentation of the state's resources adds materially to Kansas' ability to participate in the war program.

Listing of the aeronautic resources of the state is the beginning of a long range program which will culminate the Commission's hopes of making Kansas the hub of America's air industry.

Cooperating in this program is the Kansas State Planning Board. The Planning Board and the Commission have much of the information already in their files, and the two agencies will work together to combine their information and their work. Cooperation will be sought from Chambers of Commerce in all Kansas towns, and in those communities having no formally organized Chamber of Commerce a local service club will be asked to help seek out isolated industries which would not otherwise be reported upon. A field representative will make personal calls when necessary.

"This endeavor," said Price, "has a dual purpose. It will be a valuable contribution to the war production program and it will be the basis for post-war planning and development. It is a tremendous job but we are devoting all of our energy to it and expect to have it completed soon."

KANSAS INDUSTRIAL DEVELOPMENT COMMISSION

801 HARRISON

TOPEKA, KANSAS

RESTORATION OF SIGHT

Eligible for Treatment	21	81	1162
Uncompleted Treatment Cases			132
Completed Treatment Cases			
Still Eligible for "A.B." after Treatment			241
Ineligible for "A.B." after Treatment			408
Total			649

PREVENTION OF BLINDNESS

	June	1942	'38 to Date
Eligible for Treatment	12	51	619
Uncompleted Treatment Cases			113
Completed Treatment Cases			
Eligible for "A.B." after Treatment	1	2	6
Ineligible for "A.B." after Treatment			396
Totals	6	69	402
	June	1942	to Date

MINUTES

The following are the minutes of the meeting of the Society Committee on Control of Tuberculosis which was held in Topeka on August 9:

"The meeting was called to order by the chairman, Dr. Lerrigo and minutes of the last meeting were read by Dr. Trump, Secretary pro tem, in the absence of Mr. Clarence Munns. Dr. Trump also acted as Secretary for the meeting.

After an explanation of the agenda and an invitation to all members present to introduce subjects which they felt to be of importance, the first subject discussed was that of the proposed refresher course at Norton Sanatorium. This subject had already been treated at the meeting held at Wichita on May 13, 1942 and the Committee had passed a motion that a special educational program at Norton Sanatorium running through the year for physicians of the State, be worked out by a Committee to be appointed by the Chairman. Dr. Taylor agreed that for a short course of three to six days with no more than four or five students at a time, lodging and meals might be provided at one of the dormitories.

The next subject under discussion was in reference to the qualifications of doctors to give pneumothorax treatment, especially as it relates to patients ready to leave the sanatorium but needing access to a qualified physician to give pneumothorax refills. Dr. Taylor suggested that the list of physicians already qualified be revised due to the fact that so many doctors have been taken into the Army. The Chairman appointed Dr. Taylor to look into this matter and gave him the responsibility of selecting two other members to make a Committee of three. This Committee will also work out the details of the refresher course at Norton.

Dr. F. H. Guild, Secretary of the Legislative Council, stated that the Council is in favor of measures to make such increase in facilities for giving care to cases of tuberculosis as will do away with the 'Waiting List.' The Council would like more information as to conditions in Cherokee and other counties.

For Item 6 of the Agenda 'Assistance to the Kansas State Board of Health's Tuberculin Testing Program,' motion was presented by Dr. Trump, seconded by Dr. Finney as follows:

Motion—The Committee on Control of Tuberculosis urges Kansas physicians to give all possible aid to such organized tuberculin testing campaigns as are approved by The Kansas State Medical Society. It is the understanding of the Committee that the County Tuberculosis Association will budget from Christmas Seal funds moderate compensation to such physicians as assist in this work, based on \$10.00 for a full school day or \$5.00 for half day. It is understood that such a sum is by no means payment for the amount of work done but simply a recognition of valuable time expended.

Dr. Hiebert then presented the photo-roentgen method of screening tuberculosis and gave to each member of the Committee a set of mimeographed material which not only carried a brief resume of the plan but also copies of such forms as have already been approved for presentation to those taking the tests and a form to be sent to the family physician relating to such cases as were found to need medical care. Dr. Taylor made a motion that a routine fourteen by seventeen picture be made of all cases in which the miniature films might be considered suspicious. Motion was seconded by Dr. Ashmore and carried. The Chairman remarked that this being the only motion made as to the plan of work suggested by Dr. Hiebert, it would be assumed that its passage included approval of the plan as it stands at present.

Motion to adjourn was made by Dr. Spearing."

The members present were: Dr. C. H. Lerrigo, Chairman, of Topeka, Dr. F. C. Beelman of Topeka, Dr. H. L. Hiebert of Topeka, Dr. Guy A. Finney of Topeka, Dr. F. A. Trump of Ottawa, Dr. C. F. Taylor of Norton, Dr. J. W. Spearing of Parsons, Dr. E. B. McKnight of Alma, Dr. A. L. Ashmore of Wichita and Dr. D. D. Carr of Topeka were also present.

COUNTY SOCIETIES

The Sumner County Medical Society held a meeting on June 25 in Wellington. Indigent medical plans for the county were discussed. The next meeting will be held on September 17.

The Mitchell County Medical Society and the Mitchell County Auxiliary entertained with a picnic on June 17 at the Community hospital in Beloit. Dr. F. L. Loveland of Topeka, Major R. H. VanDeventer and Major H. J. Dixon of the Kansas Medical Officers Recruiting Board of Topeka presented talks on "Medical Procurement and Assignment" to the members of the Society.

MEMBERS

Dr. A. R. Hatcher of Wellington recently announced that he has closed his hospital in that city for the duration of the war.

Dr. C. Alexander Hellwig and Dr. Lewis H. Forman of Wichita are the co-authors of an article entitled, "Pellagra and Internal Secretion" which was published in the April issue of the American Journal of Clinical Pathology.

The article "The Psychiatrist in Relation to the Local Selective Service Board" by Dr. William C. Menninger of Topeka which was published in the December issue of the Journal was abstracted in the August 1942 issue of Digest of Treatment, published by the J. B. Lippincott Company.

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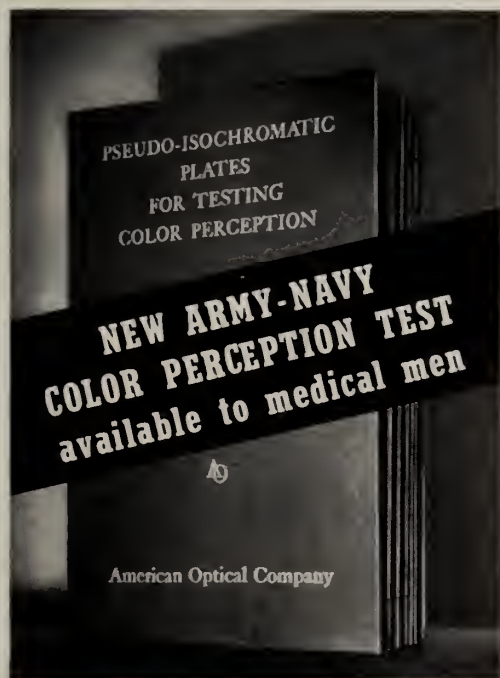
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DEATH NOTICES

Miss Joyce Ryerson, of Topeka, who was a secretary in the Society Central Office from June 1, 1938 until her illness in November, 1941, died at Hillcrest Sanitorium in Topeka on August 4th.

Dr. Paul Arthur Westbrook, 37 years of age, of Columbus was killed on August 6 when his car crashed into a train. Dr. Westbrook came to Columbus seven years ago from Portland, Oregon. He was graduated from the University of Oregon Medical School in 1934 and was a member of the Cherokee County Medical Society.

ANNOUNCEMENTS

A Conference on Venereal Disease Control in Wartime, under the auspices of the United States Public Health Service will be held in conjunction with the Eighth Annual Meeting of the American Neisserian Medical Society at Hot Springs National Park, Arkansas on October 21-24. Representatives of the War Department, the Navy Department, the Social Protection Section of the Office of Defense Health and Welfare Services, the American Medical Association, the American Neisserian Medical Society, the American Social Hygiene Association, state and local health departments, and the United States Public Health Service, will be in attendance. Surgeon General Thomas Parran will preside.

The American Board of Ophthalmology, announces the following additional examinations, because of the war emergency: New York City—December 13-16 and Los Angeles—January 15-16. Written examinations were canceled for 1943, but subjects previously covered by written examinations will be given orally. The oral examinations will cover the following subjects: External Diseases-Slit Lamp; Ophthalmoscopy; Histology-Pathology-Bacteriology; Ocular Motility; Refraction-Retinoscopy; Practical Surgery; Anatomy and Embryology; Perimetry; Therapeutics and Operations; Optics and Visual Physiology; and Relation of the Eye to General Diseases. Formal application blanks must be filed with the secretary not later than November 1. For further information write: American Board of Ophthalmology, 6830 Waterman Avenue, St. Louis, Missouri.

Announcement was made in the August issue of the Rocky Mountain Medical Journal of the cancellation of the regular annual session of the Colorado State Medical Society, which was to have been held at Colorado Springs on September 23-26.

The 1942 Clinical Congress of the American College of Surgeons, originally scheduled for October, will be held on November 17-20 in Cleveland, Ohio. The Twenty-fifth Annual Hospital Standardization Conference sponsored by the College will be held at the same time, with program of both meetings held with a Joint General Assembly on Tuesday, November 17, the following will make addresses: Surgeon General James C. Magee of the Medical Corps of the United States Army, Surgeon General Ross T. McIntire of the Medical Corps of the United States Navy; Surgeon General Thomas Parran of the United States Public Health Service, Lt. Col. George Baehr of the United States Office of Civilian Defense; Dr. Frank H. Lahey, Chairman, Di-

recting Board of the Office of Procurement and Assignment Service for Physicians, Dentists and Veterinarians: Dr. Irvin Abell, Chairman of the Board of Regents of the College and Dr. W. Edward Gallie of Toronto, President of the College.

The Omaha Mid-West Clinical Society will hold its Tenth Annual Assembly in Omaha on October 26-30, with headquarters at the Hotel Paxton.

BOOK NOOK

BOOKS RECEIVED

BLOOD GROUPING TECHNIC, A Manual for Clinicians, Serologists, Anthropologists and Students of Legal and Military Medicine by Fritz Schiff, M.D., Late Chief of the Department of Bacteriology, Beth Israel Hospital, New York, N. Y., and William C. Boyd, Ph.D., Associate Professor of Biochemistry, Boston University School of Medicine; Associate Member, Evans Memorial, Massachusetts Memorial Hospitals, Boston, with a foreword by Karl Landsteiner of the Rockefeller Institute for Medical Research. Published by the Interscience Publishers, Inc., New York. Priced at \$5.00.

STANDARD NOMENCLATURE OF DISEASE AND STANDARD NOMENCLATURE OF OPERATIONS—Edited by Edwin P. Jordan, M.D. Published by the American Medical Association, 535 North Dearborn Street, Chicago, Illinois. The preliminary printing of the book was in 1932, first edition in 1933, second edition in 1935, reprinted in 1936-1937-1938 and the third edition in 1942.

DR. FINLEY SEES IT THROUGH—Alan Hart. A novel of the medical profession published by Harper and Brothers, New York, N. Y. Priced at \$2.50.

NIGHT OF FLAME—Dyson Carter. A novel published by the Reynal and Hitchcock publishers of New York. Priced at \$2.50.

WAR MEDICINE—A Symposium—Edited by Winfield Scott Pugh, M.D., Commander, M.C., United States Navy, Retired, Formerly Surgeon, City Hospital of New York, Associate Editor, Edward Podolsky, M.D., Technical Editor, Dagobert D. Runes, Ph.D. Published by the Philosophical Library, Inc., 15 East Fortieth Street, New York City, New York. Priced at \$7.50.

CIVIL DEFENSE MEASURES FOR THE PROTECTION OF CHILDREN, Report of Observations in Great Britain as of February, 1941—Martha M. Eliot, M.D., Associate Chief, Children's Bureau of the United States Department of Labor and a member of the United States Civil Defense Mission to Great Britain. Published by the Children's Bureau of the United States Department of Labor. This small book is priced at thirty cents.

THE TREATMENT OF SYPHILIS, with Artificial Fever Combined with Chemotherapy—Results of Ten Years of

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* *Laryngoscope*, Feb. 1935, Vol. XLV, No. 2, 149-154—*Laryngoscope*, Jan. 1937, Vol. XLVII, No. 1, 58-60 *Proc. Soc. Exp. Biol. and Med.*, 1934, 32, 241—*N. Y. State Journ. Med.*, Vol. 35, 6-1-35, No. 11, 590-592

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Experience—Published by the United States Public Health Service of Washington, D. C., the booklet is priced at ten cents.

CENTRAL AUTONOMIC REGULATIONS IN HEALTH AND DISEASE, with Special Reference to the Hypothalamus—Heymen R. Miller, M.D., Associate Attending Physician of the Montefiore Hospital of New York City, with an introduction by John F. Fulton, M.D., M.A., D.PHIL. (OXON.) Sterling Professor of Physiology of Yale University. Published by Grune and Stratton of New York. Priced at \$5.50. The volume contains 440 pages, sixty-four illustrations, a bibliography and index.

ADVANCES IN INTERNAL MEDICINE—Edited by J. Murray Steele, M.D., of the Welfare Hospital, New York University Division of Welfare Island, New York. Associate Editors: William Dock, M.D., Department of Pathology of Cornell University Medical College, New York, New York; Tinsley R. Harrison, M.D., Bowman Gray School of Medicine of Wake Forest College of Winston-Salem, North Carolina; Chester S. Keefer, M.D., Evans Memorial, Massachusetts Memorial Hospitals of Boston, Massachusetts; Robert F. Loeb, M.D., College of Physicians and Surgeons of Columbia University, New York, New York; Warfield T. Longscope, M.D., The Johns Hopkins Hospital, Baltimore, Maryland; George R. Minot, M.D., Thorndike Memorial Laboratory, Boston City Hospital of Boston, Massachusetts and I Snapper, M.D., Peiping Union Medical College of Peiping, China. Volume I is published by the Interscience Publishers, Inc., of New York, New York. Priced at \$4.50.

BOOKS REVIEWED

A TEXT-BOOK OF NEURO-ANATOMY—Albert Kuntz, Ph.D., M.D., Professor of Micro-Anatomy in St. Louis University School of Medicine. Third Edition, revised. Published by Lea and Febiger of Philadelphia, Pennsylvania. Priced at \$6.00. In the first chapters of the book the study of the nervous system as a whole is taken up, acquainting the student with simple reflexes, and the correlation mechanisms in the spinal cord and brain stem. The anatomy and functional relationships of the brain divisions are simply and adequately discussed, this new edition goes into the more recent experimental clinical studies than did the former editions. Adequate references to current literature is included for most of the chapters. A splendid book for the library of the student who wishes to gain knowledge of the anatomy and physiology of the nervous system.

THE PRINCIPLES OF NEUROLOGICAL SURGERY—Loyal Davis, M.S., M.D., Ph.D., D.Sc. (Hon.). Professor of Surgery and Chairman of the Division of Surgery of Northwestern University Medical School, Chicago, Illinois. Second Edition published by Lea & Febiger of Philadelphia, Pennsylvania. Priced at \$7.00. The book was written for the general practitioner rather than the neurological surgeon. The book gives an accurate concept of neurological surgery and an intelligent approach to that problem, in order that the reader may avoid giving erroneous advice to his patients as to what can be accomplished by surgical treatment. A valuable aid to diagnosis, covering injuries, tumors and abscesses of the craniocerebral and intracranial regions and of the spinal cord, as well as pain, surgery of the autonomic nervous system, and the surgical treatment of epileptiform seizures and of essential hypertension.

ATHLETIC INJURIES—Augustus Thorndike, M.D., Surgeon in the Department of Hygiene, Harvard University; Associate in Surgery, Harvard Medical School; Associate Surgeon, Children's Hospital, Boston, Massachusetts. Second Edition, thoroughly revised, illustrated with 105 engravings; published by Lea & Febiger of Philadelphia. This would seem to be a rather valuable second edition to a monograph on athletic injuries, classifications of type and their treatment. There are graphic illustrations of bandaging and splinting, which should be helpful to a layman interested in this work.

THE TREATMENT OF INFANTILE PARALYSIS IN THE ACUTE STAGE—Sister Elizabeth Kinny. Published by the Bruce Publishing Company of Saint Paul and Minneapolis, Minnesota, and priced at \$3.50. This small volume of 285 pages contains the lectures, and is the only text book on the subject of her methods. The Kinny method for the treatment of infantile paralysis in the acute stages has received nation-wide publicity. Her methods, which are revolutionary, were evolved first in the Australian frontier and later demonstrated in Melbourne. These same methods have challenged the attention of leading authorities on the subject who encouraged her to come to the United States to continue her work. She has worked for some time at the University of Minnesota and the General Hospital in Minneapolis demonstrating to physicians that her treatment can produce remarkable results.

LABORATORY DIAGNOSIS OF PROTOZOAN DISEASES—Charles Franklin Craig, M.D., M.A., (Hon.) F.A.C.P., Colonel, United States Army Medical Corps retired, Emeritus Professor of Tropical Medicine, Tulane University Medical School; Member American Academy of Tropical Medicine, American Society of Tropical Medicine, American Society of Parasitologists; Honorary Member American Society of Clinical Pathologists. Published by Lea and Febiger of Philadelphia, 1942, the book is priced at \$4.50. This manual of laboratory methods used in the diagnosis of diseases caused by protozoan organisms. With the experience of forty years of intensive work in this field the author is placing a book upon the market which will no doubt become valuable to the profession who has often had to seek among the journals and other scientific material for any brief knowledge of the diagnosis of protozoan diseases. It will be of great value to physicians who conduct their own laboratories, to public health officials and laboratory technicians.

THE EYE MANIFESTATION OF INTERNAL DISEASES—I. S. Tassman, M.D., Professor of Ophthalmology, Graduate School of Medicine, University of Pennsylvania, Philadelphia; Attending Surgeon, Wills Hospital, Philadelphia, Pennsylvania. Published by the C. V. Mosby Company of St. Louis, Missouri. This volume of 542 pages, 201 illustrations, some in color, assumes that the eye as an integral part of the body system and an organ which may become involved or affected in the course of almost any disease, is for this reason of great importance in the diagnosis and prognosis of the disease. The arrangement of the book is simple and the normal structure of the eye is discussed for the beginner in the first few chapters. Other subjects such as congenital and hereditary manifestations, the eye manifestations in infectious diseases, and the eye manifestations in drug and chemical intoxications, are discussed in later chapters. The book is nicely indexed and well illustrated.

The Library of the Medical Department of the University of Kansas has every desire to be of service to the medical profession in the state. Any physician who wishes to avail himself of the facilities of the Library will be welcome both in the use of its periodicals, bound volumes of periodicals, and monographs and text-books.

Under certain circumstances, provided the volumes are not being actively used by the students, the Library will send such volumes as are needed to physicians in the state, on request, for a period of one week, provided carriage charges are paid both ways.

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NATIONAL FORMULARY, SEVENTH EDITION, National Formulary VII. Prepared by the Committee on National Formulary, by Authority of the American Pharmaceutical Association—which will be official from November, 1942, was recently published by the American Pharmaceutical Association of Washington, D. C. This new edition of 690 pages priced at \$6.00 has been completely revised and enlarged.

Neocalamine, a new form of calamine which more nearly approximates flesh color, is included and formulas are provided for a lotion, phenolated lotion, and ointment of this drug. These new preparations are much more agreeable to use than those made with calamine and in time will probably completely replace them.

Pectin and Pectin Pastes are found in the new N.F. to provide standards for these preparations used in the treatment of indolent ulcers, bed sores, and similar infections. Magma of Bentonite, containing five per cent of this suspending agent, is included to give the pharmacists a convenient preparation for extemporaneous prescription use.

An important feature of the new Edition is a greatly augmented section devoted to materials and preparations for use in the Clinical Laboratory. Pharmacists will find this section a comprehensive guide to the reagents ordinarily used by the Clinical Laboratory and by the physician who does laboratory examination in his office.

Seventy-one articles, official in U.S.P. XI but not admitted to U.S.P. XII, have been added to the N.F. in order to provide standards of purity, quality, and strength necessary to their use. Publication of the Seventh Edition of the National Formulary marks the first step in the continuous Revision program which has been adopted by the American Pharmaceutical Association in order to keep this compendium up-to-date with advances in pharmacy and medicine. The issuance of the new book is incidental to the prosecution of scores of research projects which are under way to develop more effective, more pleasant and more attractive forms of medication which pharmacists can pro-

vide physicians for use in prevention and treatment of disease. Other projects relate to the development of replacements made necessary by the present emergency. As new formulas are developed, they will be announced by interim revisions and, if warranted, by supplements. So rapid are the developments in pharmacy, medicine, and allied fields that no book of standards can remain static for ten years, or even five years, and retain its usefulness to practitioners in the field.

Pharmacists are urged to obtain their copies of the new Edition and to keep their prescription departments in step with the National Formulary program in order that they may promptly make available to the physicians they serve the best in pharmaceutical service that the profession has to offer.

DIRECTORY OF MEDICAL SPECIALISTS, Certified by American Boards in 1942—The Board of Editors are as follows: Directing Editor, Paul Titus, M.D., Pittsburgh, Pennsylvania, of the American Board of Obstetrics and Gynecology and Associate Editor, J. Stewart Rodman, M.D., of the American Board of Surgery Advisory Editorial Board; John Green, M.D., of the American Board of Ophthalmology; W. P. Wherry, M.D., of the American Board of Otolaryngology; Paul Titus, M.D., of the American Board of Obstetrics and Gynecology; C. Guy Lane, M.D., of the American Board of Dermatology and Syphilology; C. Anderson Aldrich, M.D., of the American Board of Pediatrics; Walter Freeman, M.D., of the American Board of Psychiatry and Neurology; B. R. Kirklin, M.D., of the American Board of Radiology; Guy A. Caldwell, M.D., of the American Board of Orthopaedic Surgery; Gilbert J. Thomas, M.D., of the American Board of Urology; W. S. Middleton, M.D., of the American Board of Internal Medicine; F. W. Hartman, M.D., of the American Board of Pathology; J. Stewart Rodman, M.D., of the American Board of Surgery; Paul M. Wood, M.D., of the American Board of Anesthesiology; V. P. Blair, M.D., of the American

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FRACTURES & TRAUMATIC SURGERY—Two Weeks Intensive Course will be offered starting September 21st. Informal Course available every week.

GYNECOLOGY—Two Weeks Intensive Course will be offered starting October 5th. Clinical and diagnostic Courses every week.

OBSTETRICS—Two Weeks Intensive Course will be offered starting September 21st. Informal Course every week.

OTOLARYNGOLOGY—Two Weeks Intensive Course will be offered starting September 14th. Clinical and Special Courses every week.

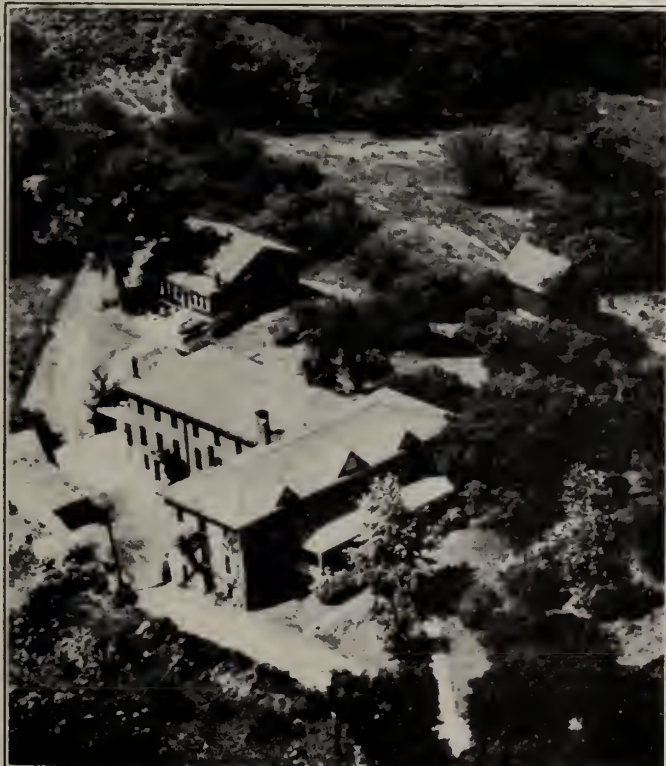
OPHTHALMOLOGY—Two Weeks Intensive Course will be offered starting September 28th. Five weeks Course in Refraction Methods starting October 19th. Informal course every week.

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can Board of Plastic Surgery; R. Glen Spurling, of the American Board of Neurological Surgery. Published for the Advisory Board for Medical Specialties by the Columbia University Press of New York. Priced at \$7.00. Since the first edition of the directory appeared more than four thousand doctors have taken their Board examinations. The directory is unique and a valuable asset to doctors' offices and other in need of this type of material. The new edition contains information on more than eighteen thousand certified Diplomates. The individual data on each doctor in this volume is more complete than that given in the one published two years ago. A separate section is given to each American Board. It also contains a complete alphabetical listing of all Diplomates with addresses and specialty certifications.

PHYSICIANS' REFERENCE BOOK OF EMERGENCY MEDICAL SERVICE: A Compilation, Chiefly from Medical Literature, Presenting the Practical Experience and Lessons Acquired in Handling Civilian War Casualties—Published by E. R. Squibb and Sons of New York. This little paper bound book of 268 pages was compiled, printed and distributed as a public service to physicians and surgeons in the Emergency Medical Service of the United States by the Medical Department of E. R. Squibb and Sons. The book carries no advertising. It contains excerpts from medical literature, largely British, presenting practical experience and lessons acquired in handling civilian war casualties, and covers general problems of civilian defense; protection for hospitals; civilian health and organization for air raid casualty work. Under casualty management are included treatment for shock, burns, wounds and their treatment, fractures, treatment for blast and crush injuries, action and identification of war gasses, first-aid and general treatment and methods of decontamination. A fine piece of medical abstracting which covers much recent literature not readily available on a vital emergency subject.

KANSAS MEDICAL ASSISTANTS

A dinner meeting of the Board of Directors of the Kansas Medical Assistants Society will be held in Topeka on September 6-7, at the Jayhawk Hotel. Officers of the organization who are expected to attend the board meeting are as follows: Mrs. Florence Linton of Topeka, President; Mrs. Edna Nichols of Hutchinson, President-Elect; Mrs. Gretchen Moddrell of Wichita, Vice-President; Mrs. Marjorie Euler of Topeka, Recording Secretary; Miss Irene Miller of Emporia, Treasurer; and Miss Virginia Kistler of Topeka, Corresponding Secretary. Councilors for the Districts are as follows: First District—Miss Pearl Scott of Kansas City; Second District—Miss Bessie Parker of Emporia; Third District—Miss Thelma Gelbach of Wichita; Fourth District—Miss Marie Schwartz of Great Bend; Fifth District—Miss Margaret O'Rourke of Dodge City. Miss Marie Schwartz is resigning as Councilor for the Fourth District as she has received her commission as a nurse into the Navy.

Dr. Henry N. Tihen, President, has announced the appointment of the following members as an Advisory Committee to the Kansas Medical Assistants Society for the year 1942-1943: Dr. J. L. Lattimore of Topeka as Chairman; Dr. J. D. Colt, Sr. of Manhattan, Dr. Irl Hempstead of Hutchinson, Dr. C. O. Meredith of Emporia, Dr. C. D. Blake of Hays, Dr. L. B. Spake of Kansas City and Dr. A. W. Feghtly of Wichita.

The Shawnee County Medical Assistants Society entertained with its annual picnic for the Shawnee County Medical Society and their wives in Topeka on July 27. Seventy members and guests were in attendance.

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AUXILIARY

PRESIDENT'S MESSAGE

Reports from the various State chairmen are beginning to come in, outlining their hopes and aspirations for the coming year. Each one has such a thorough and complete understanding of what she hopes to accomplish that I feel we will make great strides even if only a part of each goal becomes a reality.

The Executive Secretary of the National Auxiliary has just assured me that the bulletin will be in your hands in the next few days. From it I know we will all find helpful suggestions and inspiration.

Dr. Tihen's outline to the Auxiliary Advisory Committee shows such an understanding of our work, I know we have a good and true friend at the helm of The Kansas Medical Society.

The early part of September I will get my son off to college and move my family back to town and be ready to greet the members of the Board at the annual fall Board meeting. Please have an early fall meeting of your county units so there will be no delay in getting our program under way.

Sincerely,
Mrs. C. Omer West.

AUXILIARY NEWS

The Central Kansas Medical Auxiliary met on June 18, at the home of Mrs. F. S. Hawes in Russell. Mrs. J. B.

Carter of Ellsworth presented a report on the Auxiliary activities at the annual State convention in Wichita. Mrs. C. D. Blake of Hays gave a report on the Auxiliary meeting of the American Medical Association held in Atlantic City, New Jersey.

The Mitchell County Medical Society and the Mitchell County Auxiliary held a picnic on June 17 at Beloit. While the Society listened to the guest speakers the wives of the members held a business meeting.

Swing High, Swing Low—Two figures have been recently released by the United States Bureau of Census, which make good reading for all of us interested in the coming of babies. In 1941, there were more babies born than in any other year of our history, except one. And in 1940 the maternal mortality rate was the lowest in history, barring none—37.6 for every 10,000 live babies born.

The National birth rate in 1941 was 18.8 as compared to 17.9 in 1940. The Census Bureau noted that the German birth rate stood at twenty in 1940, and has been declining since then. Population experts, however, are still fighting it out among themselves as to whether this increase in the birth rate is a reversal in trend.

While the low maternal mortality rate is a sign that motherhood is safer in the United States, nevertheless, the Census Bureau points out that the 1940 maternal mortality rate for negro women was nearly two and one-half times as high as that for white women. The reduction in the maternal mortality rate for 1939 to 1940 was accounted for entirely by the reduction in the rate for white women from thirty-five per 10,000 live births to thirty-two.—Briefs, Maternity Center Association, N.Y.



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SOME NUTRITIONAL PROBLEMS OF THE NEONATAL PERIOD*

Alan Brown, M.D., F.R.C.P. (Lond.)

Toronto, Canada

The nutrition of the newborn infant is the most important stage in the feeding of infants, because the establishment of breast feeding, while it should be a natural function, is in modern times difficult, and yet breast feeding is the most successful form of nourishment.

If the infant requires artificial feeding the tolerance of the newborn infant to foreign food is extremely low and any break in tolerance at this early period is almost invariably the cause of future troubles in nourishment.

BREAST FEEDING

Breast feeding is a function of which there should be little to learn in the year 1942, yet never probably has breast feeding given so little cause for satisfaction as at this time. During a survey made a number of years ago by the author¹ it was found that Canadian mothers nurse their infants less than do those of foreign extraction; that the well to do nurse their infants less than do those of poorer classes; that maternal nursing is less today than it was twenty-five or thirty years ago in Canada, but that in view of propaganda in the child welfare clinics of our city there has been a noticeable improvement; that the infrequency of nursing depends chiefly on the ignorance of the laity and the indifference of the physician. It is our duty as physicians to remedy this evil.

The late Abraham Jacobi, in New York, stated that "there is no such thing as complete absence of breast milk; that every woman can nurse her infant, and that it behooves the diligent nurse and physician to see that she does". Every physician will agree that there are some women who cannot, such as those suffering from debilitating diseases and the neurotic

type, but unfortunately it has become the rule in all too many instances for the physician to state that the milk does not agree with the infant, without an adequate trial, the result being that the child is fed according to the "canned directions," frequently with the inevitable result. There is no test which will tell whether a milk is good, bad or indifferent, except the infant. If the baby is thriving the food is all right, if it is not, there is either something wrong with the infant, which can be determined by physical examination, or else the food is deficient either in quantity or quality. It is up to the physician to determine these factors.

Many babies are weaned in the first few weeks of life. In some cases, it seems, natural feeding is not attempted. Mothers who succeed in nursing very commonly require help in the nourishment of their infants, and there is recurring familiar difficulty in prolonging function to its term. Every country records a similar experience. Even in child welfare centres, where breast feeding forms the first article of a universal creed, the percentage of breast-fed babies rarely reaches 100.

There is happily little doubt that some of the difficulties are fictitious. If this were not so, the degree of failure must surely be looked on more seriously, since reproduction as a whole process is concerned, and not merely one of its phases. If lactation is abrogated or cannot be made to act, if the reproductive cycle cannot be concluded, if the child must go unprovided, how shall that function itself be safe? Will the failure presently be extended elsewhere where it is more obviously destructive? But these questions are left without answers in an age that in most spheres is intent on extending physical achievement rather than contracting and relinquishing it.

The issue cannot be dismissed on economic grounds, since the poorest mothers are not those who commonly find difficulty in breast-feeding. Arbitrary decisions to wean must also, of necessity, be discounted as a large factor. But there may have been something of a moral change, wide-set in the community, that injures breast feeding nearer its source, since successful nursing seems no longer to be considered a matter of prestige. The privileges of breast-

*Presented at the 83rd Annual Session of The Kansas Medical Society, Wichita, May 12, 1942.

feeding have somehow become overshadowed, and there is common ignorance as to what functioning actually entails. Here, if she but knew it, the mother may find some of her best experience in a service of unequalled value to a child. Yet women seem very often not to be oppressed by their failure in this that is act and pact of true motherhood.

There are many women who still nurse their babies successfully, and who would never fail in this duty, but these do not predominate amongst the educated class. Women of this sort feel the impress of any factors operating nervously and physically to disturb balance, and simple processes are apt to become difficult. In spite of a cult of parent-craft, it is here that the most elementary of its privileges becomes most readily abandoned, and the child suffers the injury of weaning.

There are mothers who say that in spite of much eagerness they have failed to secure the necessary teaching in breast feeding. Certainly some mothers require tuition. The doctor in charge may often be sorely tried if his training has shown him more of artificial feeding than of the subtle details of nursing technique. The person most intimately associated with the mother, however, is the nurse, and she it is who, a figure of undisputed authority, is alleged most often to find the greatest difficulty in keeping the baby at the mother's breast. All of these factors may account in part for a problem that, if it were real, i.e. biological, would surely be the most serious that any generation could meet.

There are further interferences still that have little to do with physiology. The field for commercial exploitation is large in this connection, and makers of artificial foods vie with one another in proclaiming the virtues of their wares. Mothers receive the full onslaught of a whirlwind of advertisements and of propaganda most ingeniously worded to assail their faith. Before their time is come, almost, they have begun to believe that they "can't nurse their babies" or that the offspring of their efforts will be "bonnier" if not subjected to the toils of the breast. Breast-feeding, in consequence, has not gained in public estimation, and many who would have breast-fed have not dared persevere under the implication that this is an ordinary way of infant nurture, and that babies must not be deprived of anything "scientific" or "good" merely to save the instinct of the mother to nourish and care for them herself. In these circumstances the first onset of symptoms natural to a new physical activity is apt to be acclaimed as a proof that "the breast is not agreeing", or delays are quoted as evidence before there is any reason to doubt the response. Fathers anxious that their wives should be comfortable are readily persuaded of the

"strain" of breast feeding. Utterly anticipated by the interests concerned, the present day passion for "hygiene" has here failed to make good, and there has been no crusade to come to the aid of nature and good sense. The truth, however, remains as it was. Breast feeding is a function that depends in the first place on good general health. The general health of the community has improved incontestably with better habits of dieting and hygiene and a raised standard of living. There is every reason to suppose that, with a little due concentration and the necessary statement of relevant facts, breast feeding should be easier and more certain than ever before².

COMPLICATIONS

Colic and insufficient nourishment.—Up until fifteen or twenty years ago I think it was the general impression that when babies suffered from colic, this colic was due to overfeeding with breast milk. We now feel that most colic in the newborn is due to insufficient nourishment, especially if one bears in mind the observations made after careful study of the average infant and comparing it with the puppy.

One of the most frequent diagnostic mistakes regarding the nutrition of the infant is the error of confounding colic with hunger in the newborn. Newborn infants suffer nowadays not from overfeeding with breast milk, but from lack of it. For every case of overfeeding we probably see ninety-nine instances of so-called hunger colic. Practically all young mothers, overtaking their strength in their eagerness to be up and about after their long confinement, harried by old wives' tales and conflicting advice of well-meaning neighbours, secretly afraid of the new baby, and frightened that he is going to die at every squirm and grunt and yawn, run short of milk toward the end of the day.

As a friend of mine, Dr. Eugene Rosamond, said: "Milk production is milk production, whether in womankind or the lower animals. A Jersey cow if frightened or teased about her calf will give perhaps a quart of milk at the next milking time instead of the expected three gallons. Even a hog or a dog that drives her from the pasture, or a strange milker will affect the quantity of her milk. A woman is much more susceptible to nervous reactions. Milk production in all our minds is associated with green meadows, still nature and kind faced old cows standing in quiet streams (not listening to a baseball game or a prize-fight over the radio.)

"A modern, educated woman is not a kind faced, stolid milk machine, and so she always at some time or other runs short of milk. And then the baby cries. And when the baby cries his stomach hurts him. Have you ever thought how the whole world is ob-

sessed with the idea that every time a baby cries his stomach hurts him? The pediatricist has added ears to the list of places a baby can hurt, but when the ears are examined and found normal, then he too usually says the baby's stomach hurts him. So night after night when the tired, worried mother runs short of milk, the baby cries. He cries, he screams, he gets red in the face and doubles up; he kicks and straightens out, and rears back in a perfect paroxysm of "rage"; he gnaws at his fist and his mother's face; he tries with every way he knows to show he is hungry, but still he has the stomach ache. Finally, when he is comfortably full of hot water or medications, he goes to sleep, and he awakens the next morning as if nothing had happened. But the next day late, when the tired family wants to go to bed he "pulls another party." He is a smart looking baby, he holds his head up well and his back seems strong. He is preternaturally bright and the neighbours all say they never saw such an intelligent looking little baby. He is a light sleeper and the whole family has to be quiet to keep from waking him. Occasionally a young father, untrammelled by old women's tales will have a lucid idea and say "If that were a puppy I'd say he was hungry and feed it," and there is no better appeal to their understanding than the illustration of the hungry puppy. The signs of hunger in other animals are usually recognized, because they are not hedged about with a mass of superstition and empirical nonsense. The hungry puppy is wakeful. He wakes with the slightest scrape of the foot on the floor. He gets up every few minutes and hunts for a softer place to lie. He is the smart dog who handles himself well, and in begging for food is all a-wiggle as if his muscles were of rubber. He is preternaturally smart and bright. Usually he is the runt who is crowded away from the breast by the stronger puppies, and because he appears smarter he is considered the pick of the litter. The full puppy is lazy, stupid and relaxed.

"The full baby is a stupid little animal. One who is easily waked, who is especially smart and intelligent looking, one who handles himself too well for his age, he is a hungry baby. You can walk in the nursery, take one look at such a baby and absolutely diagnose the cause for your visit just the same as you can stand at the foot of the bed and see a rapid respiration with flushed face and an expiratory grunt, and know the baby has pneumonia³."

There is no difference of opinion as to the therapy in hunger colic.

THE HYPOTONIC OR VAGOTONIC INFANT

In spite of the vast amount written on pyloric stenosis there still exists failure to distinguish it from hypertonia or vagotonia. In pyloric stenosis

the cardinal symptoms are forcible vomiting, loss in weight, diminution in fecal and urinary output, while on physical examination typical waves may be seen and on palpation the tumor usually felt. In contrast to this we have the vagotonic or hypertonic infant with a history of incessant crying (unrelieved by dietary change), often forcible vomiting, and either diarrhoea or constipation. The mother will often volunteer the information that the baby appears to be very strong for his age, even at one or two weeks of age she will frequently state that he lies with his head in the position of opisthotonus, his muscles alternately contract and relax, and his extremities exhibit often a pipe-stem rigidity. Occasionally she will remark that the baby almost jumps off her lap while she is bathing him. On examination, these babies are irritable and crying most of the time. If held up by the shoulders they can be supported by the elbows alone and can often stand quite erect on one foot, which of course is always contrary to the findings in a normal infant.

Feeding is a difficult problem. This baby is always crying and hungry. He may take only small amounts of his feeding. He will swallow the first mouthful or two voraciously and then dawdle or refuse the rest. On other occasions he may take the entire quantity of food prescribed, regardless of the amount, and then cry for more. On the four hour interval he will start crying well before feeding time. More frequent feedings will be given but this will not solve the problem and it may accentuate the vomiting.

Vomiting is a common symptom and is due to spasm of the pylorus. In fact, the entire gastro-intestinal tract is subject to increased activity, giving rise to what is commonly known as colic. There is a popular lay idea that colic is a normal occurrence in many infants for at least the first three months, after which time it should disappear. This may be true, but the so-called "colicky" baby is usually nothing but a hypertonic infant. True hypertonia never produces pyloric stenosis. Pyloric stenosis is a congenital hypertrophy of the circular muscle fibres and is an entirely separate clinical entity. This physiological disturbance is due to an autonomic imbalance. Whether this instability is dependent upon a hereditary factor or is an outgrowth of our hectic civilization, one cannot say, but this type of infant appears to be on the increase. With nervous, excitable parents, the symptoms may be accentuated.⁴

TREATMENT OF VAGOTONIA

One must bear in mind that while the vagus is pressor to the pylorus and paralysis causes dilation, the action on the anal sphincter is the reverse. Inhibition of the vagal action allows full play of the sym-

pathetic and as a result the anal sphincter may be contracted. Consequently we frequently see constipation. The early morning dose of atropine may sometimes be omitted to permit relaxation of the anal sphincter and thus allow an evacuation.

The treatment of course in this condition is a free exhibition of atropine sulphate. Sidney V. Haas has pointed out that atropine in solution is not reliable because the solutions are difficult to accurately compound and there is always the danger of overdosage. Furthermore the solutions deteriorate rapidly and the dosage cannot be properly regulated. It is much wiser on his suggestion to use homeopathic tablets of atropine sulphate in 1/1000 of a grain. These tablets retain their strength and one can easily regulate the increase in the dose. In the use of atropine one must remember that the signs of toxicity are fever, rash, dilation of the pupil and excessive dryness. The appearance of these signs are not serious and should cause no alarm as they promptly disappear when the drug is withheld. We have seen instances of hypertonic infants where a total dose of 1/10 of a grain of atropine has been administered over a period of twenty-four hours. Such a large dose given initially would have killed the baby. These infants are extremely tolerant of atropine. The tablet should be given in a little water just prior to the feeding, not fifteen minutes before, as is often done. One occasionally observes a baby that is a little sensitive to this dose but this can be overcome by reducing it. Transient flushing of the cheeks shortly after administration may be disregarded. With the appearance of signs of a reaction the atropine should be omitted until the symptoms disappear. In renewing the dosage, begin with a smaller dose. The tolerance to the drug increases and where 3/1000 grain caused a rise in temperature at first, it will not occur again until 5/1000 grain is reached. Much of the dissatisfaction from its use in the early days resulted from the administration of solutions which are either too strong, or too weak and failed to help the patient.

In addition to atropine it has very frequently been found beneficial to add 1/8 to 1/6 of a grain of phenobarbital to each dose.

It is surprising and gratifying to see the change following the use of these drugs in infants who are restless, cry all the time, seem forever hungry, never sleep, and vomit frequently. They become more quiet, sleep peacefully, eat contentedly and retain all their food. It has been found that the medication can usually be stopped anywhere from two to five months, as symptoms subside. In rare instances the manifestations may persist until the baby is almost one year of age¹.

ALLERGIC FACTORS

The gastro-intestinal tract of the infant especially in the neonatal period is permeable to undigested proteins. That this is responsible for the development of sensitivity is now not disputed by observers. Ratner points out that the newborn infant can be sensitized either actively or passively. Active sensitization occurs when a normal mother during pregnancy develops an unusual craving for certain foodstuffs, such as milk, eggs, fruit, etc., and by taking an excess amount of these foodstuffs actively sensitizes the fetus in utero. As soon as this food is given after birth, symptoms of allergy may appear. Ratner cites the case of an infant seen at two months with an eczema of both cheeks. This developed seven weeks before, that is when the infant was one week of age, following the administration of a simple milk formula supplementing the breast milk. When the formula was given the child vomited. The antepartum history revealed that the mother took from two to three quarts of milk and three to four eggs a day. According to the postpartum history she did not eat excessively of any food. Protein skin tests showed a positive reaction to lactalbumin and whole milk. On a denaturated milk formula the child did well, did not vomit and the eczema gradually subsided.

Passive sensitization takes place when the mother herself is sensitive and transmits the antibodies through the placental circulation to the fetus. In contrast to active sensitization, which is limited to food alone, passive sensitization may also involve the respiratory system with disturbances caused by pollens and animal epidermals. Since sensitization of a human being can be acquired in utero, it follows that allergy is not alone dependent on chromosomal inheritance¹.

One of the most frequent clinical observations to be made is when a newborn or older infant refuses its first dose of cow's milk. A series of severe symptoms may occur immediately after or some hours following the first dose of milk. Protein skin tests in instances of this type are invariably negative and yet if this condition is not recognized these infants are frequently fed on various changes of diet and are buffeted around from pillar to post without a full appreciation of the etiological factor concerned. The removal of milk of all types, including evaporated milk which has been cooked for six hours, or the substitution of a non-milk food such as Sobee, brings about prompt relief. A newborn infant invariably receives a few ounces of cow's milk during the first week while the breast milk is being established. This procedure introduces the foreign protein to which the infant later becomes sensitized and to which he may react many weeks or months later when a further addition of cow's milk is made.

As an illustration of the gravity of the symptoms that may be produced, the following case is an example which was seen in our hospital in March 1942. Baby F. nine days of age, was admitted on account of frequent loose stools of one week's duration and rapid grunting breathing. The family history revealed the fact that the maternal aunt has had since six years of age a burning pain in the throat and abdomen on drinking milk, and has developed a rash over the body within a few minutes after drinking milk, the rash lasting several hours. No other allergic history was obtainable. The rest of the personal and family history was quite irrelevant. Present illness—Following delivery the baby was nursed in the usual manner. At one week of age he was given a protein milk supplement because the stools were loose. The following day the breast milk was discontinued because there was insufficient amount and a protein milk formula given. The following day the baby became ill and had rapid, pauseless, grunting respiration. Physical examination revealed a fairly well nourished infant of six pounds breathing rapidly and appearing desperately ill. There was some evidence of dehydration brought about by the rapid breathing and loose stools that the baby had the day before. Complete chemical examination of the blood revealed nothing of significance. The child was given intravenous therapy, and barley water only was given orally. There was a striking improvement on the introduction of this food and it was only then that suspicion arose to suggest that the child might be allergic to cow's milk. He was given an adequate diet of Sobee and has made an uninterrupted recovery. Later on he was tested for both cow's milk and breast milk, and showed a positive reaction to both.

I think that in all feeding difficulties in the newborn, which difficulties might cause severe symptoms, or even those with mild symptoms, the question of milk allergy should be uppermost in our minds.

VOMITING AND DIARRHOEA IN THE NEWBORN PERIOD

Vomiting which occurs as a result of the use of a modified milk or evaporated milk and water feeding immediately after birth may be due to some obstruction which may vary from oesophageal stricture, spasm or stenosis of the pylorus, to a complete atresia of any part of the intestinal tract. Vomiting due to atresia or stenosis as a result of congenital malformation would naturally occur during the first few days. The symptoms would also depend to a large extent on whether the obstruction is high up or low down. Immediate vomiting of course of unchanged food occurs in tracheo-oesophageal fistula. Instances of

duodenal bands and atresia of the upper part of the intestine strongly simulate instances of pyloric stenosis. Vomiting may also be due to some infectious process as a result of either sepsis or meningitis. Of course, improper technique in the manner of feeding should always be taken into consideration, as not infrequently a too free flow from the nipple will cause vomiting. Vomiting then in the neonatal period requires careful investigation in order to determine the cause. Occasionally a too high fat mixture will produce vomiting.

Diarrhoea in the newborn on a simple milk mixture is unusual. It should be classed as toxic or non-toxic. In the non-toxic group merely the elimination of added sugar and the addition of calcium caseinate in the form of casec, four tablespoons to the quart, may be sufficient to overcome the looseness of the stools. If however there are signs of toxicity, it may be wise to starve the infant for a period of eight to twenty-four hours, depending upon the seriousness of the disease and the health of the infant, and to administer fluids in the form of saline and glucose parenterally.

Infectious diarrhoea in the newborn is uncommon, but during the past ten years sporadic epidemics have occurred in some of the large maternity hospitals throughout the country. The disease is a distinct entity characterized by the sudden onset of diarrhoea, slight fever, dehydration, and complications of the ear and respiratory tract. This condition is attended by a high mortality (from forty to forty-five per cent). It should not, however, be confused with summer diarrhoea, dysentery or alimentary intoxication which it resembles, especially in those cases which fail to recover. In fact the great difference is in the highly contagious nature of this infection in the newborn period.

The first manifestation is loss of appetite. This is shortly followed by fever which ranges from 101 to 103 degrees. Diarrhoea is the characteristic symptom present from the beginning. The age of its appearance is usually from two days to three weeks, most often at the end of the first week following birth, and this fact indicates a very short period of incubation. The number of stools may vary from six to sixteen daily. However, in occasional cases the diarrhoea is not severe. The stools may be formed or watery with curds and mucus and their appearance does not necessarily signify the severity of the disease, as some people have found fairly normal stools in very sick infants. Vomiting is usually not a prominent feature, or dehydration severe, especially in those babies that get better. However, where death is the end result the loss of weight is marked and rapid and in these cases cyanosis and pallor are prom-

inent and the impression is one of shock, with death occurring in spite of frequent blood transfusions and other intensive therapy. Bacteriological studies usually have failed to reveal a very definite causative organism and the wisest plan to employ to control these cases is to close the nursery in order to prevent the spread of the disease.

The treatment of the condition is the same as the usual procedures that are followed for the treatment of alimentary intoxication in older infants, namely a free exhibition of fluids by mouth and parenterally, and repeated blood transfusions, and employment of breast milk.⁴

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A. M. A. Census—Some interesting figures about the physicians of the United States have been secured as a result of the census taken by the American Medical Association's Committee on Medical preparedness.

These figures, some of them never available before, were reported by the committee in Atlantic City. About 158,000 out of the total 180,000 listed in the 1940 American Medical Directory, or approximately eighty-six per cent, filled out and returned the questionnaire. For the remaining 22,000 who failed to do so, incomplete schedules were filled out in the Bureau of Medical Economics or at the headquarters of state medical associations with all available information so that the punch card filed would contain at least a minimum of information about every physician in the United States.

It is obvious, of course, that deaths, changes of address and practice and new admissions make constant changes necessary and from the beginning of the census a routine has been established for making alterations as soon as information is received.

As a result of two years' effort, records and punch cards are now on file for more than 181,500 physicians in the United States and its outlying territories and possessions. Of this number some 176,000 are located in continental United States.—Minnesota Medicine.

In 1975, two hundred years after the shot that was heard around the world—we will be an old nation in years and an old nation in population.

According to the Census Bureau's estimate, in that year of the future with a total population of some 152,000,000 beings, only 19.4 per cent of the population will be youths fourteen years of age or less. Today this age period constitutes 25.1 per cent of the nation.

In line with this prediction, we will also have less fighting men of the best soldier age—the early twenties. So if we are going to make the world safe for "non-aggressor nations," we had better do it before 1975.

But perhaps by then, we will be also older and wiser as a nation as well as individually.—New York State Journal of Medicine.

THE CONTACTS OF THE LAW WITH MEDICAL PRACTICE*

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In our discussion of the contacts of the law with medical practice, we have chosen to divide the subject matter into three parts: A brief discussion of medical licensure; some reference to the problem of malpractice; and finally, a few remarks concerning the service of the medical profession to the courts, particularly the expert witness.

The earliest legal regulation of the medical profession of which we have knowledge was found in the code of Ham mur abi of Babylonia, whose reign has not been accurately fixed. Various dates from 2287 to 2067 B. C. have been mentioned as the probable beginning thereof. The code of Ham mur abi meticulously regulates the practice of medicine and surgery. The fees to be charged for services to various classes or casts of patients were fixed. In some cases it seemed to be required that cures be guaranteed, for: "If the surgeon has operated upon a gentleman and caused his death or caused the loss of the gentleman's eye, one shall cut off his hands"; namely, the offending member shall suffer the punishment. "If he has caused the death of a slave, the doctor shall render slave for slave; while for the loss of a slave's eye, he shall make pecuniary compensation²".

LICENSURE

The earliest continental law of medical licensure was apparently enacted by Roger II of Sicily in 1140. It read in part, "Whoever will henceforth practice medicine, let him present himself to our officials and judges to be examined by them; but if he presume of his own temerity, let him be imprisoned and all his goods sold at auction. The object of this is to prevent the subjects of our kingdom incurring peril through the ignorance of physicians²".

"In the United States the first statutory regulation seems to have been adopted in New York in 1887. This was followed in the same state in 1818 by a more general and comprehensive law providing for the organization of county and state medical societies with boards of censors to which was committed the power to examine applicants and issue licenses. But in 1844, for reasons which are now to us wholly incomprehensible," says Oppenheimer⁷, "all acts regulating the practice of medicine and surgery in

*Read at a joint meeting of the Wyandotte County Medical Society and the Wyandotte County Bar Association.

New York were repealed." In the expressive language of the New York Court of Appeals, "The legislature made every man a doctor, and nostrums of every description and admixture could be safely prescribed and payments therefor exacted by authority of law. Thirty years later, however, in 1874, the legislature enacted a regulatory measure which has from time to time been amended and supplemented, and which is now sufficiently comprehensive to protect the public in reasonable measure against the charlatan and humbug." Since then, individual states have passed acts designed to regulate the practice of medicine in its various branches. Our own medical practice act, in itself antiquated, has been modified and modernized by adopted rules of our Board of Registration and Examination.

In most instances, the statutes of the various states regulate those in practice to limited branches of medicine or pseudo-medicine. Thus, we have legal regulation of the practice of midwifery, chiropody, chiropractic, dentistry, optometry, osteopathy, naturopathy, neuropathy and perhaps others. Much could be said of the inconsistency of the legal requirements designed to regulate and safeguard the public which seems not to be applicable equally to the various cults designated by legislative licensure. As an example, laws and rules of public health require the licensed doctors of medicine to keep themselves abreast of the times in diagnosis and therapy. The infectious or contagious disease such as smallpox, typhoid fever, measles, etc., must be recognized by the doctor of medicine, quarantine instituted and the case reported to the health department. In the event he fails to do so, his license may be revoked, he may be fined or imprisoned. On the other hand, the cultist may deny the existence of such infectious disease, treat the patient by the laying on of hands or otherwise and thereby relieve himself of the necessity of complying with public health requirements with impunity so far as the law is concerned. The fact that epidemics of small pox and other infectious or contagious diseases do not more often occur is accomplished by public health education and the watchful eye of health officers rather than regulation of the practice of medicine as defined by the law.

The inconsistency of legislative regulation of the practice of medicine can hardly be laid at the door of the legal profession. However, in our discussion of the contacts of the law with medical practice, its consideration is pertinent. So long as the health of the community is as completely in the hands of the recognized profession as now exists, no doubt the consequences of unscientific organizations will continue to have a minor effect.

While we are discussing licensure, the library fee should be mentioned. Unless it is paid annually, a Wyandotte County physician may not testify that he is legally licensed. Its payment is required by state law in lieu of the payment of a city occupation tax; the officers of our society are required to notify him of his delinquency and if delinquent he may not practice in Grade A hospitals, do insurance work or sue to collect professional fees.

MALPRACTICE

Turning our attention, then, to the matter of malpractice, we in Wyandotte County would first like to pay compliment to the legal profession concerning their attitude to physicians. That more malpractice suits are not filed or prosecuted, reflects perhaps not so completely the high degree of efficiency of the profession of Wyandotte County, but rather the fairness in the attitude of the legal profession in the advice to their clientele.

A definition of malpractice is difficult. Literally, it means bad practice. For our purpose it may be defined as the failure on the part of the physician properly to perform the duty which develops upon him in his professional relations to his patient, resulting in some injury to the patient. The omission or failure of the physician to perform such duty is negligence defined by law and is the prerequisite upon which damage is to be assessed. Oppenheimer⁷ defines that there can be no actionable negligence unless there be: first, a legal duty on the part of the defendant to protect the plaintiff from any harm from the defendant's want of skill or care; second, failure on the part of the defendant to perform that duty; and, third, injury to the plaintiff which is traceable directly to the defendant's breach of duty. He says, quoting a series of references, that the absence of any one of these essential requirements is fatal to any legal claim. The law requires the physician to exercise the average degree of skill, care and diligence exercised by members of the same profession practicing in the same or similar locality in the light of the present state of medical and surgical science. It is pointed out that the highest degree of skill or care is not required and that the degree of skill of the specialist cannot be demanded of the general practitioner. The physician is to be judged by a standard of individuals of the same school, practicing in the same or similar locality. The fact that the service is rendered gratuitously does not absolve the physician in any sense.

The use of approved remedies and appliances is pre-requisite and the best judgment is required in their application. The law requires that the science of medicine is not, and in the very nature of things, may not be, permitted to become static for our

knowledge of the human body and the function of its various constituent parts is constantly increasing. Conversely, new, untried and unapproved remedies or appliances may not be imposed upon the physician's patient. An estimate of the Medical Protective Company, large writers of professional liability insurance, points out that fifteen per cent of all malpractice actions are based on the allegation of the failure of the physician to avail himself of the benefit of x-ray examination. That the law recognizes the progress in medicine is told in two Supreme Court decisions separated by only six years, wherein one indemnified the patient's family when the patient died of a head injury in which x-ray pictures of the skull had been taken, successfully holding that something as the result of the x-ray examination contributed to the patient's demise. The other decision, six years later, indemnified the family of a patient who also suffered a head injury, the physician negligently failing to examine the skull by x-ray.

There is much of interest in the history of malpractice suits but, as Gormly⁴ points out, it should be emphasized that the history of malpractice, compared with the history of medicine, is in its infancy. The first malpractice suit of which record is given was the case of Slater vs. Baker and Stapleton in England in 1767. This was an action which arose over the treatment of a fracture of both bones of the leg and in which a verdict of 500 pounds was reached for the plaintiff. Previous to this time, these actions were brought as a criminal charge for assault. The first American case was in 1794 in Connecticut and the defendant, after the suit was filed, made some sort of agreement with the plaintiff that the bill for an operation on his wife, who had died, would offset any claims of personal injury. The jury did not agree with the defendant and gave the plaintiff forty pounds and costs⁴. It is estimated by Dr. Stetson⁹, President of the Massachusetts Medical Society, 1931-33, that five years previous thereto, approximately 20,000 malpractice suits were filed in the United States. There are some ten to a dozen threatened suits for each suit which actually goes to litigation. We concern ourselves here entirely with the civil malpractice suit, recognizing, of course, the existence of criminal malpractice. The great mortality between the threatened and actual suits, in the opinion of most writers, comes from a misconception by physicians, lawyers and laymen that a bad result constitutes negligence by inference. We mean that in spite of a high degree of knowledge, skill and excellent care, that mistakes and errors of judgment will occur and that their occurrence is in no sense a basis for court action.

It has been repeatedly shown by statistical studies

that one chief cause of threatened and actual malpractice actions is to be laid at the door of the profession itself. Unguarded remarks on the part of fellow practitioners, such as, "Who has been taking care of this case?", 'I am sorry that I did not have an opportunity to attend this case in the first place', 'I am afraid your case has got into such bad shape, etc.', and 'Dr. Blank ought to be ashamed of himself, etc.', constitute thoughtless but nevertheless the most potent factor in the initiation or actual prosecution of malpractice actions. One might deal at length in description of such situations but of all facts clearly proven is the outstanding advantage which accrues to the doctor who sees the patient last. Everyone of experience in the practice of medicine appreciates that the next doctor who sees the patient will have the advantage. Truly, the last looker has the best look is an axiom proven daily. Many suits, either threatened or actually filed, are countersuits. It is estimated that twenty per cent of malpractice suits are an effort on the part of the patient to avoid payment of professional fees. One writer even goes so far as to say that seventy-five per cent of such suits are blackmail. It is agreed that the number of malpractice suits in the United States has increased tremendously and we in Wyandotte County feel particularly fortunate in our low percentage.

A frequent cause for suit is the leaving of a sponge or foreign object in the body at operation and it should be emphasized that the responsibility in such a case is the surgeon's and not the hospital's. The best defense for a malpractice action is identical with the best insurance against its occurrence, viz: Carefully kept records, x-ray examinations whenever conceivably indicated, written permission for operations and post-mortem examinations, the operative record, pathology report and especially the avoidance of gossip remarks about other doctors' work. We believe that the most important single consideration in addition to these assurances is the immediate consideration of actual or threatened suits by a competent and authoritative committee of the organized profession.

Such a committee is provided for in the constitution of the Wyandotte County Medical Society, known as the Medico-Legal Committee, whose duties are to advise with the defendant in any malpractice suit, survey the evidence and the elements of the treatment, to appoint witnesses in the defendant's behalf, to adjudicate the question of contest or compromise and confer with the attorneys and witnesses for the prosecution in malpractice cases concerning the merits of a threatened or actual suit. Our Medico-Legal Committee, which consists of nine members, has another function which leads to a discussion of

the third division. This committee will, on request, advise with the medical experts in personal injury or corporation cases with the idea of promoting a substantial justice. They may attend the trial as spectators, in person or by proxy, of cases bearing medical testimony involving either malpractice or personal injury, listen carefully to testimony offered and later review the testimony among themselves. Finally, they are charged with the responsibility of the preferment of charges before the society against any member whose testimony is contrary to modern scientific knowledge.

It has been the experience in other counties where such a committee of the local society exists that fake malpractice suits, when brought to the attention of this committee, peter out promptly. Attorneys have asked for a hearing before such a committee, realizing the advice thereby obtained to be of more value than the curbstone advice of some doctor who could not be possessed of the necessary facts upon which to base his judgment⁴. The actual legitimate malpractice case is rationally assisted to the same extent that fake cases are caused to disappear.

A new threat has recently appeared and should be mentioned. The publication or portrayal of photographs, motion pictures, radiographs or case histories, may be, and have been, the subject of suit on the basis of libel and trespass on hypothetical right of privacy.

MEDICAL WITNESS

And now as concerns the physicians' contact with the courts: namely, the expert witness. The matter of expert testifying in court is not the ordeal pictured by some people who have occupied the witness stand and who are quoted repeatedly in the literature of medico-legal relations. There is a natural dread of the witness chair similar to the fears of a small boy who is about to speak his part and is afraid he will forget an important line. Anxiety as to one's ability to think clearly and express himself likewise is justified in any such situation. It is time-consuming and remuneration is only fair. It is somewhat of a duty but not a task. It should be remembered as one chides the flustered expert witness, that very few persons in the court room, spectators, jurors, attaches or attorneys could face calmly situations which are daily occurrences to the physician. Mark Twain once said "There is no display of human ingenuity, wit and power so fascinating as that made by trained lawyers in an important case. Nowhere is there such an exhibition of subtlety, acumen, address or eloquence". The good trial lawyer is an artist at cross-examination and plans his attack with corresponding cunning. The witness who has been candid and truthful may expect from him straight-

forward questions but if he has not been truthful, has unintentionally or otherwise given the impression of prejudice or bias, he may expect a barrage that will tend to discredit not only the testimony but the witness himself.

Criticism and prejudice of the expert witness is frequently heard. Honorable John M. Gallagher, Chief Justice of the Supreme Court of Minnesota³, believes that one cause for prejudice has arisen against the testimony of the physician as the result of difference of opinions of experts in mental cases. He points out that they occur in important will cases and in criminal cases under the plea of insanity and are traceable to the difference between legal and medical concepts of insanity. He explains that in law, insanity implies inability to recognize wrongfulness of an act and is based on outmoded mental science and psychology. He says that to the physician and psychologist mental derangement may be entirely unconnected with any responsibility. The psychology which expresses itself in criminality seems the very embodiment of irresponsibility to the physician and yet in law the criminal is held responsible. Be that as it may, difference in opinion by physicians is not more frequent than among other experts. To be sure, the difference of opinion and interpretation forms the basis of most questions submitted to litigation.

Another frequent criticism of the physician's testimony is facetiously referred to as consisting of a jargon of technical phraseology which is unintelligible to the judge and jury. I found with some amusement, in a brief review of the literature concerning the expert witness, a short poem referred to again and again wherein a black eye was described as "an integumental contusion with adjacent ecchymosis of orbital tissue⁶."

Medicine possesses its own literature and language and the most natural tendency is for the physician to lapse into technical phraseology particularly when encouraged by the attorney who can at least engage in medical phraseology to a knee depth. Frequently it is forgotten by both witness and attorney that the matter of their discussion is for the benefit of the judge or the jury and a dialogue ensues—a dialogue not too enlightening to a jury who have become casual listeners.

It is my belief that medical testimony too frequently is characterized by an attitude on the part of the medical witness that he is making a record, because of the presence of the court reporter, and he visualizes his answers to counsel's questions being critically read by a jury of physicians. In other words, he feels as though he were writing a book or scientific article for publication. But all responsibility for

language and terminology does not rest with the doctor. Unfortunately, the doctor must answer the questions only. Springstun⁸ in his book "Doctors and Juries" says that testifying in court is a good deal like playing golf. If the doctor takes a good stance, keeps his eye on the ball, uses a good swing and follows through, he gets along pretty well. The simple dignified swing without exaggeration or added flourishes always gets the best results.

Lawyers complain about and criticize the expert medical witness, no doubt justly, but physicians have complaints also. Physicians as a class object to the hypothetical question as a technical problem to be twisted at will by the interrogating attorney but all too frequently so involved as to be beyond the comprehension, in all or even most of its details, to the witness himself and surely, we believe, to the lay members of the jury. Lawyers recognize the disadvantage of the hypothetical question. Professor Wigmore¹, quoted to the writer as pre-eminent on matters of evidence, says: "The hypothetical question must go as a requirement. Its abuses have been so obstructive and nauseous that no remedy short of extirpation will suffice, the hypothetical question is mis-used by the clumsy and abused by the clever, has in practice led to intolerable obstruction of the truth."

We have another complaint. The physician resents the legal phraseology found in the petition. He is embarrassed when he reads the petition of his own patient describing common-place bodily injuries with which he deals daily, so dressed up in legal phraseology and so exaggerated in compliance with legal technical detail as to be hardly recognizable. Why not write a petition like an insurance policy, with standard provisions in small type to cover all possible surprises and then a written part that reads more sensibly? Furthermore, why do most injuries become complicated by sacroiliac sprain when suit is filed?

Then, too, I think it should be emphasized that we can see no conceivable parallel between legal liability and the extent of permanency of injury. There seems to be a tendency by some attorneys to forget this fact at times. We all hope that the time may come, in this as well as in other states, when medical experts may become "arms of the court" rather than "aids of the partisans". It is partially possible now under our compensation laws and it is entirely possible, for medical referees are provided for in the acts of other states.

It has been said that some lawyers can get a doctor to testify and prove almost any allegation. We hope that is not true. Perhaps it only seems so when different sets of symptoms are emphasized by adroit

opposing lawyers making testimonies sound so different. Then there is the human side. The expert witness who must testify in most actions does so with the knowledge that any compensation must come from the coffers of his employer. A contingent fee is unethical, but at the same time, a feeling of obligation is natural. Physicians are only human beings and represent a cross-section of the moral standards of man; the mean considerably higher than the average by reason of education and calling, but nevertheless motivated by the same influences as those which move all men.

Then there is the criticism of the physician as illustrated when the patient goes to the doctor's office and is treated by his physician, basing the treatment on subjective symptoms. The same physician as a medical witness testifies in a similar case that there is no disease because there are no objective signs. It is my belief that the explanation is that one is the practice of medicine, while the other is a technical consideration of pure scientific facts. The medicine of the courtroom is not the medicine of the sickroom. The responsibility for the difference, as I see it, is the law. The rules of evidence, we learn, forbid the consideration of subjective symptoms, except those stated under oath, an inconsistency which the medical witness finds difficult to understand. It must be apparent that the examination of a patient without the privilege of conversing with him would be a very laborious if not impossible task.

The Kansas Supreme Court defines the basis of the physician's expert opinion in the much quoted case of *Frazier vs. Atchison, Topeka and Santa Fe R. R.* 27, Kansas 463, the opinion written in 1885¹. It confirms the finding of the lower court in assessing \$1000.00 damages against the defendant, wherein six physicians agreed that Mrs. Frazier suffered traumatic neuralgia following an injury to the head. The opinion forbids that subjective symptoms related outside the courtroom form the basis of an expert opinion and has qualified physician's testimony ever since. That neuralgia seldom presents any but subjective symptoms even after fifty-four years further study is an interesting coincidence.

It is my sincere belief that the chief cause of misunderstanding between the legal and medical professions is the conception of lawyers of medicine as approaching an exact science. Medical science is not medical practice. Any part of medicine which has been raised to an exact science needs merely medical technicians and not physicians for its accomplishment. Such is the case of many of the diagnostic tests. As Haggard² illustrates, it once required the consummate skill of a physician to determine in some cases the presence of syphilis. Now, a far more

accurate diagnosis is made by a technician in the laboratory. True medical science is represented by research workers. The practicing physician is far more than a scientist; he has been referred to by some as an artist. He does not deal with the control and limited matters of the laboratory; he deals with human beings. So long as the human mind in its full ramifications remains beyond evaluation by scientific precision, then the practice of medicine must remain an art. Physicians view with alarm the tendency of medical training to become divorced from medical practice, and feel that the emphasis upon science and upon the laboratory has extended down into the pre-medical field in college to the detriment of the young doctor. We have the feeling that the courts consider the practice of medicine with too great emphasis on the scientific aspect of medicine and that attorneys think of us as medical research scientists rather than artisans of the practice of medicine.

Since the advent of the Workmen's Compensation Commission a change for the better concerning rules of evidence has been accomplished, but the requirement of the evaluation of disability it includes, has been a thorn in the side of physicians who attempt to offer expert testimony. Here again it is difficult for the legal profession to comprehend the inability of the experts to render an opinion of disability based on pure scientific evaluation. The methods in use throughout the United States differ greatly. Earning capacity, vocational utility, structural defect, cosmetic impairment, are all general considerations in the different methods of rating. No universal standard has been accepted, although there is an increasing demand that disability be based upon functional impairment. Function to one may mean motion; to another, coordination; to another, power; and to still another may mean the summation of all three factors. A severe fracture deformity may be accompanied by little or no functional disturbance while a minor structural change may occasion a severe functional disability. Our conception, then, of the worker should be that of a social and economic unit and the end result of an industrial accident should be appraised not on the basis of structural change alone but on that of disturbed function. On the face of it, it is apparent that such determination requires the evaluation of a physician experienced in practice and learned in the recuperative ability of the injured employee.

We as physicians are seriously interested in our obligation to society including our contribution to law and the doing of justice. As has been written, no physician designed the statute of the Goddess of Justice else she would hold the balance in her strong,

steady right hand and simultaneously would put less emphasis on her sword. Medicine appreciates its imperfection and grasps almost too quickly sometimes for what is newer and better. It is faddish and physicians are gullible. However, medicine grows in wisdom with the years. An accepted practice can be cast off with the ease of an old coat when research finds something newer and better. In contrast, law clings to its precedents and its traditions. The plan no doubt is as it should be; we need the abiding nature of the law to guide our progress and stabilize our course, but the contrast is there just the same. There is, and should be, no criticism of the professions of the law and medicine but the individuals who make them will do well to take critical stock of themselves in recurring meetings such as this.

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German industry has been advised to employ 400,000 persons who have active tuberculosis to save labor power, the British radio reported on May 5, quoting an article in one of the leading German journals on tuberculosis.

The text of the broadcast, recorded at the Columbia Broadcasting System short wave listening station, is:

"Men and women suffering from tuberculosis of the lungs are working in many German factories and are to be employed to an even greater extent.

This is indicated by an article which the Dresden lung specialist, Dr. Elizabeth Dehnoff, published in the April issue of the German Journal on Tuberculosis.

She says, 'Most enterprises employ without any hesitation workers suffering from acute tuberculosis.' She then advocates the absorption of more than 400,000 persons suffering from acute tuberculosis in industrial establishments, as Germany can not afford to dispense with such valuable labor power.

Dr. Dehnoff adds, "These sick people should be employed on work where they do not come in contact with other persons, so that they can earn their living without risking infection of others."

German health statistics indicate that the number of cases of tuberculosis in Germany increased by twenty-five per cent during the first two years of the war.—From Bulletin of National Tuberculosis Association.



REPLACEMENT THERAPY IN ACHLORHYDRIA

A CLINICAL STUDY*

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Since Ewald first began to do gastric analyses, the subject of altered gastric secretions has been of interest to both physiologists and clinicians. The symptomatology, physiology, pathology and value of replacement therapy have been debatable subjects.

The views regarding the importance of gastric anacidity range from those who consider it largely an involutional phenomena¹ of little clinical significance to those who consider it capable of causing severe ill effects.

Achlorhydria is found with carcinoma of the stomach, pernicious anemia, syphilis of the stomach, nontropical sprue, and pellagra. Also it is frequently associated with arthritis, microcytic anemia, nephritis, gallbladder disease, a few skin diseases and the debilitating diseases, especially diabetes. Our chief purpose in making this survey was to evaluate the effectiveness of hydrochloric acid therapy in patients with gastro-intestinal symptoms and achlorhydria in the absence of organic disease and with organic disease other than pernicious anemia and carcinoma of the gastro-intestinal tract.

STUDY BASED ON THREE HUNDRED CASES

In our clinic examination of a standard Ewald test meal is done routinely, and except in a few cases for special study, is the only test made. Fractional analyses and histamine stimulation are rarely done. We realize that some cases we have diagnosed achlorhydria are possibly only hypoacidity, but we have found for practical clinical usage the Ewald test meal is adequate. About four per cent of cases showing no acid with the Ewald meal will show some response to histamine stimulation². Our routine therapy for achlorhydria is to give fifteen to twenty drops of dilute hydrochloric acid three times a day with meals.

Three hundred cases covering a period of approximately ten years were studied and questionnaires sent to them. Seventy-five per cent were also interviewed in the clinic after two or more months' treatment. Of the cases studied, we were unable to find any organic disease in 152 cases; but many of them were of an extremely nervous type and a defin-

ite diagnosis of psychoneurosis was made in nineteen instances.

Of the remaining 148 patients achlorhydria was found associated with fifty-five cases of gallbladder disease, twenty-five cases of organic heart disease, nine cases of allergic dyspepsia, eight cases of myxedema, seven with arthritis, six with pellagra, five with arteriosclerosis, four with diabetes mellitus, and one with chronic alcoholism; twenty-eight cases were associated with a large number of other conditions none of which was carcinoma of the gastro-intestinal tract, or pernicious anemia.

The majority of these cases were in the fifth and sixth decades of life. There were no cases under twenty years of age; from twenty to forty years fifteen per cent, forty-one to sixty years fifty-three per cent, and sixty-one to eighty-four years thirty-one per cent. The youngest patient was twenty years and the oldest was eighty-four years; eighty-four per cent of these patients were over forty years of age.

Of the 300 cases, 206 answered the questionnaires in a reasonable time. Most of the patients who did not answer were seen five to ten years previously, and these letters were returned. Of the 206, ninety-eight took the medicine more than one year but 112 were still taking the acid; the greatest length of time the drops were taken was eight years and the shortest two months. Many patients discontinued treatment several times but resumed treatment because the symptoms recurred. Of the 179, all reported that their entrance complaint was improved.

Of the nineteen cases diagnosed psychoneurosis, thirteen were helped and six were not. Of the thirty-four gallbladder cases, twenty-eight were helped and six were not.

Of the 152 cases without associated pathology studied, we received questionnaires from ninety-three, of which sixty-seven were interviewed.

The symptoms complained of by these ninety-three patients in the order of their occurrence were: diarrhea in thirty-three cases, gas and bloating, epigastric distress, sore tongue, nausea, headache, dizziness, weight loss, weakness and poor appetite.

Of the thirty-three patients with diarrhea, only two were not improved by the acid drops; they were definitely made worse. Of the sixty patients with other symptoms predominating eleven reported that they were not helped; forty-nine were helped. Forty-three gained weight while on treatment. Thirty-four remained the same weight. Sixteen lost weight while on treatment.

Nearly all of these patients seen in our clinic had been under treatment for their complaints before admission but had had no acid as part of their medication. Many of them were also given sedation for

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the first few weeks. Most of these patients had received sedatives prior to coming to our clinic. Some have reduced the number of dilute hydrochloric drops to five because of a burning sensation. Others have increased the drops to sixty or more and had added improvement without burning.

The essential points of this study are grouped in Tables I and II.

TABLE I
INCIDENCE OF ACHLORHYDRIA AND ASSO-
CIATED ORGANIC DISEASE*

	Number of cases	Per cent
No associated organic disease	152	50+
Associated organic disease.....	148	49+
Gallbladder disease	55	37+
Organic heart disease.....	25	17+
Allergic dyspepsia	9	6
Myxedema	8	5
Arthritis	7	5
Pellagra	6	4
Arteriosclerosis	5	4
Diabetes mellitus	4	3
Chronic alcoholism.....	1	0.3
All others	28	18
TOTAL	300	

TABLE II
EFFECT OF HYDROCHLORIC ACID THERAPY ON
SYMPTOMS IN ACHLORHYDRIA

Based on 206 Followed-up Cases

	Number of cases	Symptoms relieved: Number	Per-cent
Achlorhydria without asso- ciated pathology	93	....	....
Symptoms:			
Diarrhea	33	31	94
Gas and bloating .....	....	....	....
Epigastric distress .....	....	....	....
Sore tongue .....	....	....	....
Nausea	60	49	81
Headache .....	....	....	....
Dizziness .....	....	....	....
Weight loss .....	....	....	....
Poor appetite .....	....	....	....
Achlorhydria with associated gall- bladder disease	34	28	83
Achlorhydria with associated psy- choneurosis	19	13	65

DISCUSSION

The usual functions attributed to hydrochloric acid in the stomach are as follows: (1) it inhibits bacterial growth; (2) activates the pepsin rennin ferment; (3) swells protein fibers; (4) helps regulate the motility of the stomach; (5) ionizes iron and makes it more easily assimilable; (6) inverts cane sugar; and (7) aids in the absorption of certain vitamins and calcium. Ivy believes that it acts as an activator for the gallbladder emptying hormone cholecystokinin.

Many of these functions have not been substantiated by scientific experimentation; but the work of Moore³ on the value of acid in the ionization of iron

and the work of Shay, Gershon-Cohen and Fels⁴ on the motility of the stomach in achlorhydria are especially worthy of note.

It is well known that achlorhydric stomachs empty more rapidly than normal, and that there is frequently an associated hypermotility of the upper intestine as well. Shay, Gershon-Cohen and Fels have shown in their studies with the water barium meal that when the water was replaced with 0.1 per cent hydrochloric acid the increased motility of achlorhydric stomachs was reduced to normal. We believe many of the beneficial effects obtained by hydrochloric acid therapy in achlorhydria could be accounted for on this basis.

The improvement of those patients with achlorhydria and associated gallbladder disease is particularly notable: eighty-three per cent of the patients in that group were helped. It seems logical that any slowing of upper intestinal motility would be beneficial to those patients already having a gallbladder that does not function well. In the group with associated psychoneurosis, sixty-six per cent were helped and these patients respond poorly to any therapy, regardless of whether they are associated with achlorhydria.

SUMMARY

Three hundred cases of achlorhydria were studied and over seventy-six per cent of these were definitely helped. In those cases where diarrhea and other gastro-intestinal symptoms predominated the percentage of improvement was even higher. We believe the value of acid therapy even in small doses is probably due to the regulation of the motility of the gastro-intestinal tract. We do not believe the improvement with acid therapy is psychic but is physiologic and should be given to all achlorhydria patients with or without associated organic disease.

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Shoe Sterilizer Built at Sheppard Field—Construction of a shoe sterilizer at Sheppard Field, Texas, the Army's newest and largest air corps technical school, was ordered by Capt. Morton Hack, commanding officer of the 408th School Squadron, Air Corps Replacement Training Center.

The air-tight wooden cabinet, now being built, will be placed on wheels and will contain forty-five pairs of shoes at one time.

"By combining once-a-month inspection of the feet of the entire personnel, treatment of the feet found to be infected, and a periodic treatment of the shoes and stockings of the soldiers in the shoe sterilizer, a complete elimination of ringworm can be attained," according to Captain Hack.—*The Diplomat*, April, 1942.

*Excluding gastro-intestinal carcinoma and pernicious anemia.

CHRONIC PEPTIC ULCER IN CHILDHOOD

REPORT OF A CASE

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Chronic peptic ulcer in childhood is not rare but is uncommon. It is probable that more cases would be diagnosed if: (a) Parents did not disregard the complaints of the children, (b) A history was more readily obtainable from children and (c) The examiner kept the possibility of ulcer in mind.

Up to 1925 Proctor¹ was able to find only eleven cases in the literature and added one more of his own. Foshee² was able to find six more cases and added one more. He found an additional fifteen reports up to 1932. Since that date Willingham³ and Logan and Walters⁴ have reported cases bringing the total up to thirty-six appearing in the literature. Because of recent interest in this condition, the following case is reported.

CASE REPORT

On May 20, 1941, J.K., white, age ten years, complained of intermittent epigastric pain of one month's duration which had followed an acute attack of coryza. He vomited easily and frequently and this relieved his distress. The pain was sharp, came on in the afternoon and was most severe if he had eaten an inadequate lunch. The pain awakened him regularly at about 2:00 a.m.

Occurrence of pain at night was accompanied by twitching of the legs and nightmares. Induction of emesis or ingestion of food would give relief. He had gained no weight for about a year. For three months he had been studying hard, eating irregularly and sleeping poorly.

While taking the history the mother volunteered the information that the attack was exactly similar in all respects to a condition which had existed for six months at eight years of age; a diagnosis of chronic appendicitis had been made and x-rays of the colon taken. This report stated, "Some tenderness was found in the region of the head of the cecum." The appendix was removed at the time and relief was obtained for one and a half years.

On examination the patient was well developed. There was a lower right rectus scar which was healed. Tenderness was noted just to the right of the midline, half way between the ensiform and the umbilicus. All other findings, including reflexes, blood and urine, were negative. A provisional diagnosis of peptic ulcer was made and roentgen examination was done June 14, 1941, at the West Suburban Hos-

pital. The findings were, "There is noted a constant deformity of the duodenal cap characteristic of duodenal ulcer. The deformity is not slight nor does it appear of recent origin. It is a tie which is usually encountered only in ulcers of several years duration."

Treatment by a modified Sippy regime with high vitamin intake was instituted and to date there has been complete freedom from symptoms. The patient has gained about ten pounds since first seen. X-rays were repeated February 2, 1942, and reported improvement but deformity due to scar still present. Undoubtedly at some time in the future it will be necessary for this child to undergo surgery but to date it has been refused.

COMMENT

If the fact that peptic ulcer does occur in childhood is kept in mind the diagnosis should not present any great difficulties. However, it is not always easy to obtain a chronological history from the young and one is prone to consider only the more commonly occurring conditions. The relief obtained from the appendectomy was probably due to the rest and dietary regime he received at the time.

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An outbreak of mumps in a military establishment may lead to serious consequences in the way of days lost through hospitalization, Conrad Wesselhoeft, M.D., late Captain, Medical Corps, United States Army, Boston, and Charles F. Walcott, M.D., Major, Medical Corps Reserve, United States Army, Cambridge, Massachusetts, declare in the current issue of War Medicine, published bimonthly by the American Medical Association in cooperation with the Division of Medical Sciences of the National Research Council. Present day basic knowledge of the nature of this disease and an understanding of how some of its manifestations can be alleviated and its spread prevented, should enable one to cope with it more successfully than in the past, the two men say.—Journal of Indiana State Medical Association.

Reduction in Motor Vehicle Deaths—According to provisional figures released by the accident statistician of the Kansas State Board of Health, there were twenty-seven motor vehicle deaths in the State during the month of May, as compared to thirty-seven such deaths reported in May, 1941. The total for the first five months of this year is 137, whereas in the same period last year the motor vehicle accident toll was 188. By months, this year, each one has shown a decrease from last year's figures with the exception of January, when there were thirty-two deaths—one more than in January, 1941. Dramatic reductions have been shown, however, since tire rationing went into effect.—Kansas State Board of Health News Letter.

ARTERIO VENOUS ANEURYSM

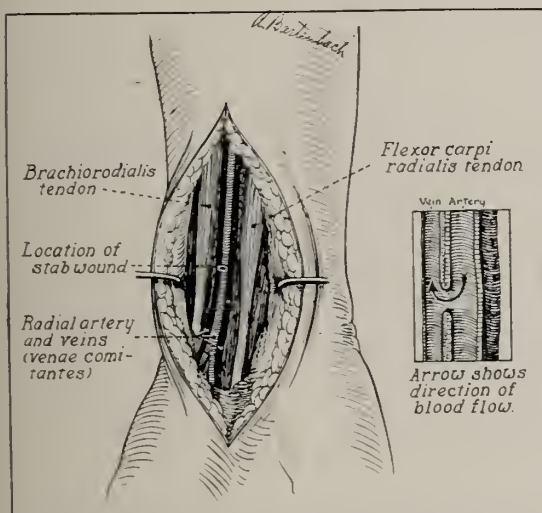
H. W. King, M.D.

John H. Luke, M.D.

Kansas City, Kansas

The existence of an abnormal arterio venous communication is rare enough to create a new interest when encountered. It is fitting now to reconsider these injuries, which are expected to be more frequent in war times. This fact is readily understood when the causative agent is a stab or gun shot wound.

Arterio venous communications may be either the direct anastomosis between the artery and the vein, the so called aneurysm varix or the indirect communication through an intermediary or communicating sac, the varicose aneurysm.



Dissection of wrist showing location of stab wound through radial artery and vein. Insert shows direction of blood flow through aneurysm which resulted from stab wound.

The treatment is concerned with the preservation of the circulation and thus the retention of the normal function of the affected part. In the great vascular trunks, for example, carotid, iliac, etc., it is essential that collateral circulation be established after a lengthy period of waiting or that the injured vessels be repaired. In the lesser vascular trunks, for example the radial artery and vein, the case study which Dr. King and I present, has to do with the removal of the aneurysm since the collateral circulation is sufficient.

CASE REPORT

Mr. X, aged twenty years, worked as a "boner" at a packing house. His job consisted in removing the bone from certain pieces of meat. For this "boning"

procedure he used a long thin knife. While at work he stabbed himself in the left wrist. The wound was very small, really the width of the boning knife—about one-half inch. This wound was dressed by the nurse and dismissed as trivial. Increased pain and numbness brought the patient to the office. At this time a diagnosis of hemorrhage into the tissue was made and a snug bandage was applied. The pain grew more intense and the swelling more pronounced so that the patient was hospitalized. X-ray was negative.

The nature of this injury was masked by the extensive extravasation of blood into the tissues. Later the vein, radial, became dilated and a definite pulsation could be seen. A purring thrill could be felt over the aneurysm, a continuous buzzing or "machinery" murmur with systolic intensification could be heard over the swelling, compression of the proximal artery caused the bruit to disappear, collapsed the vein and caused the pulsation to cease.

With these signs and symptoms, a diagnosis of radial arterio venous aneurysm was made. The aneurysm was removed by Dr. King and myself, whence the numbness of the hand and arm disappeared and the patient returned to work symptom free.

A.M.A. Directory Delayed—There will be an unavoidable delay in the issuance of the 1942 American Medical Directory because of the large number of changes of address of physicians and the difficulty of maintaining necessary office personnel, according to a recent announcement in The Journal of the A.M.A. The new edition will appear about September 1 rather than in June or July as in previous years.

Advice to Britishers in wartime from Sir John Boyd Orr, expert on nutrition, leader in the League of Nations' committee on nutrition, gives the lowly potato a hand:

After milk (and Britain has enough milk to drink a fifth more) and vegetables (and Sir John says eat twice as much), the most important food produced in the tight little isles is the potato. It is a protective food, the main source of one of the vitamins. In England an average of only four pounds of potatoes per week per person are eaten. Some countries eat twice as much.

"Some women are afraid to eat potatoes because they think they are fattening," remarked Sir John. "This is nonsense: one pound of bread and butter is more fattening than four pounds of potatoes.

"If you think you are too fat, cut out the bread and butter and eat potatoes and vegetables. In a time of threatened food shortage, the potato is by far the most important crop, because, in addition to its special health value, it gives the highest yield of food per acre. An acre of potatoes gives twice as much food as an acre of wheat."—Science News Letter.

President's Page

CLARENCE MUNNS

In 1934, The Kansas Medical Society employed its first executive-secretary, Clarence Munns. During the years since then his excellent work for us and his steadfast devotion to the ideals of Kansas medicine and to the doctors of Kansas have made for him an unusual place in the esteem and affections of the medical profession of our State.

His unfailing interest in our problems, his unflagging energy and industry in our behalf, his wisdom, his foresight, his insight into many difficult situations, his fairness, his integrity, and many other fine qualities have been demonstrated time and again during these past eight years.

It is now with the keenest regret and with the sense of a great loss that The Kansas Medical Society is losing his services for at least the duration of the war—we hope not for longer. Clarence has had no compulsions for entering the Service except his own feelings and wishes to enter actively into the service of our country during these difficult times. We admire and respect these feelings, although regretting the loss of his services.

Clarence, to you Kansas medicine wishes good luck, Godspeed, and a safe return to us after the war—our debt to you is great, our esteem is very high, our affection is deep.

Sincerely,

Henry N. Tichen, M. D.

President, The Kansas Medical Society.

EDITORIAL

CLARENCE G. MUNNS

The editors of the Journal are going to miss Clarence Munns. His departure to join the Army Air Forces leaves a gap in the home ranks which will be hard to fill. We particularly feel that he is responsible for a large share of the improvements in this publication in the past eight years.

We know, however, that every member of The Kansas Medical Society feels as keenly the loss of our extremely efficient and well liked secretary. It was Clarence's deep conviction that he could be of more use to his country in the Army than at home and the editors of this Journal heartily admire and respect such a conviction.

The Army recognized Clarence's ability by awarding him a commission as First Lieutenant in the Air Force. He is at present attending school in a southern training center.

The following letter was written by Munns on the eve of his departure to the officers and councilors of the Society. It contains a message to all of our members.

"I am leaving for duty with the Army Air Forces on September 2, and although I cannot adequately place my feelings into words, I do desire to attempt to tell you how much I have enjoyed working for you, and how much I have appreciated the numerous kindnesses, courtesies, and assistance you have given me.

Certainly, no one could have had a better employer or employment than I have had during the past eight years. The memories I have obtained during that period will always remain with me, and I leave with the hope that I may be fortunate enough to again be your employee at some future date.



You have an excellent organization and it is well on its way to becoming the most efficient and effective organization in the State. Likewise, its foremost achievement is the fact that it is built round the entire membership rather than any one individual or group of individuals.

A very capable committee has been appointed to select a new secretary for this office, and I am certain that its decision in that connection will enable your central office to continue efficiently, and more efficiently than it has in the past.

Again I wish to express my sincere appreciation for your assistance and numerous kindnesses. Likewise, if you would be good enough to express my appreciation of those matters to your membership I shall greatly appreciate your doing so.

With kindest regards, and best wishes."

CLINICAL SOCIETY MEETINGS

Announcement of the cancellation of the meeting of the Colorado State Medical Society and of the possible cancellation of other state medical meetings brings on the swift realization that many meetings of this type will of necessity be called off. It is believed, therefore, that medical publications, small district meetings, and clinical meetings will become of greater importance to the medical profession at this time than under ordinary circumstances. The time element and transportation are of great importance. There is, however, a great need for doctors of medicine to acquire as rapidly as possible the latest in medical and surgical knowledge, including new or substitute drugs which will affect the profession in a world at war.

Word has been received in the office that the Kansas City Southwest Clinical Society, the Oklahoma City Clinical Society and the Omaha Mid-West Clinical Society have all scheduled meetings to be

held in October. Scanning the list of outstanding speakers who will appear before these three meetings, we believe that members should make plans to attend at least one of the clinics.

The Kansas City Southwest Clinical Society meeting will be held in Kansas City, Missouri at the Municipal Auditorium on October 5-8. Refresher courses will be presented; round table conferences, scientific and technical exhibits, movies, radio broadcasts, and alumni dinner will be included. The following guest speakers will appear on the program: Dr. Thos. E. Carmody of Denver, Colorado; Dr. Geza de Takats and Dr. N. Sproat Heaney of Chicago, Illinois; Dr. W. A. Fansler, Dr. Wesley W. Spink and Dr. S. Marx White of Minneapolis, Minnesota; Dr. Richard H. Freyberg of Ann Arbor, Michigan; Dr. Robert Graham, D.V.M. of Urbana, Illinois; Dr. R. B. Henline, Dr. C. P. Rhoads and Dr. Philip D. Wilson of New York, New York; Dr. B. R. Kirklin of Rochester, Minnesota; Dr. Cobb Pilcher of Nashville, Tennessee; Dr. Fred W. Rankin of Washington, D.C.; Dr. Robert L. Sanders of Memphis, Tennessee and Dr. Norman C. Wetzel of Cleveland, Ohio.

The Twenty-fifth Annual Meeting of the Oklahoma City Clinical Society will be held at the Biltmore Hotel in Oklahoma City on October 26-29. Emphasis has been placed on traumatic and industrial phases of medicine and surgery. The registration fee includes all meetings, dinner, smoker and roundtables. The following is the list of guest speakers: Dr. James E. Paullin of Atlanta, Georgia; Dr. Isaac A. Bigger of Richmond, Virginia; Dr. George M. Curtis of Columbus, Ohio; Dr. Frank H. Ewerhardt of St. Louis, Missouri; Dr. Frederick H. Falls of Chicago, Illinois; Dr. Charles C. Higgins of Cleveland, Ohio; Dr. Sara M. Jordan of Boston, Massachusetts; Dr. John Albert Key of St. Louis, Missouri; Dr. Byrl R. Kirklin of Rochester, Minnesota; Dr. Andrew W. McAlester III of Kansas City, Missouri; Dr. Donovan J. McCune of New York, New York; Dr. Frank J. Novak, Jr. of Chicago, Illinois; Dr. Albert O. Singleton of Galveston, Texas; Dr. Tom D. Spies of Cincinnati, Ohio; Dr. Howard C. Taylor, Jr. of New York, New York; Dr. Willard O. Thompson of Chicago, Illinois and Dr. Eugene F. Traub of New York, New York.

The Omaha Mid-West Clinical Society will hold its Tenth Annual Assembly in Omaha, Nebraska on October 26-30, at the Hotel Paxton. Speakers scheduled for the meeting are as follows: Dr. Frank H. Lahey of Boston, Massachusetts; Dr. H. H. Riecker of Ann Arbor, Michigan; Dr. P. D. Wilson of New York, New York; Dr. A. E. Hansen of Minneapolis, Minnesota; Dr. F. E. Seneor of Chicago, Ill-

inois; Dr. Temple Fay of Philadelphia, Pennsylvania; Dr. H. M. Weber of Rochester, Minnesota; Dr. F. W. Bancroft of New York, New York; Dr. Samuel Iglauer of Cincinnati, Ohio; Dr. W. J. Dieckmann of Chicago, Illinois; Dr. I. H. Page of Indianapolis, Indiana, Dr. E. L. Sevringhaus of Madison, Wisconsin, and Dr. R. L. Haden of Cleveland, Ohio.

NURSES' AIDES

Nurses' Aides, the volunteer organization under the supervision of the American Red Cross and the local Civilian Defense Office, the Journal believes is one of the finest and soundest movements that has so far resulted from the war situation.

In regard to the Nurses' Aides, the Office of Civilian Defense in Washington, D. C., released the following information on August 5: "To date 32,000 women have enrolled for Volunteer Nurses' Aides training of which 19,000 have satisfactorily completed the course. With but few exceptions these Nurses' Aides have received their training in hospitals on approved lists of the American Medical Association and the American College of Surgeons. The results in quality of service have been satisfactory to both the hospitals and the Red Cross Chapters conducting this project."

These blue gowned women have volunteered, without pay, to train themselves adequately to assist the hospitals, to relieve the nursing shortage and to aid in any emergency.

An editorial in the September issue of Hospitals, the Journal of the American Hospital Association has the following to say in regard to this project: "The call for 3000 registered nurses per month to meet the requirements of our armed forces will impoverish the nursing profession in every hospital in this country. For more than a year we have advocated the training and employment of volunteer Nurses' Aides in our hospitals. We have held that this training could be accomplished, and the services utilized, under competent supervision, and that in a large part the draft of the institutional nurse could be met with these trainees. Instead of a few hundred now being trained in hospitals for this kind of service, one hundred thousand could be kept constantly in training and the nursing service maintained on a satisfactory level."

In Kansas this need has been realized for some time and many women have been trained throughout the State, each completing the required eighty hours of instruction in the seven allotted weeks. Many of these volunteers have families and the 150 hours which the Nurses' Aides agree to give, preferably within a three months period each year, must

in many cases entail a great deal of sacrifice both to herself and to her family.

Kansas can well be proud of her Nurses' Aides. This great network of volunteer women will go far to relieve the nurse shortage, the war strain of overcrowded hospitals, and will instill in the trained nurses with whom they work a feeling of inspiration and comradeship.

TIRE RATIONING

The following explanation of tire rationing is given as some requests have been received as to how the rules apply to physicians.

"The applicant must show that the vehicle is to be used exclusively for his professional duties." (Page 7 of the Tire Rationing Guide.)

As interpreted by various Rationing Boards, this means that a car that is eligible for re-tiring shall not be driven for any purpose, other than those stated in the application. Even if the present tires on the car were not supplied by a Rationing Board, if information is obtained by the Board that the car has been driven for pleasure or purposes other than would fit into the proper classification, then tires shall be refused the applicant.

This interpretation of course would not apply to any car other than the car designated as a business car.

Physicians in Kansas will no doubt cooperate with the various Rationing Boards in an effort to conserve rubber.

TUBERCULOSIS CONTROL

INDUSTRIAL HEALTH*

The recent reformation which has taken place in the health and life of the industrial worker in Britain is one of the most impressive and remarkable chapters in the progress of preventive medicine. It records a development from disorder, neglect and confusion to regularity and discipline, and from arbitrary mismanagement to scientific planning. It has become physiological, social and personal in objective. This is of national importance, for it affects five or six million men and women workers in the factories, and twenty million workers outside them. It sets a standard for all employment, and crystallizes British conceptions and traditions. It is perhaps the most popular of all public methods of preventive medicine, and has in it the elements of a liberal education. It improves and fortifies the individual health of the workman—his only capital—increasing his

dividend, lengthening his life and enlarging his opportunity and personality. It affects the whole man—his habits and character, his domestic life, his family and his home as well as his workplace. It is a great school of citizenship and health education of body, mind and spirit.

The worker himself, and not his factory environment, is the vital factor. His fitness, capacity, endurance and willpower are the chief requirements in order to prevent that overstrain, fatigue and disharmony which may be the precursor of disease. This is the center of gravity.—Industrial Health, Sir George Newman, Britain Today, Feb., 1942.

THE TUBERCULOUS IN INDUSTRY*

For years the after-care attention meted out to post-sanatorium cases has been the Cinderella of the Tuberculosis Service. This has been due to a variety of reasons. In the main, the results were less spectacular than those of the operating theatre and hence never achieved the same popularity in the lay mind; and again with a floating peacetime unemployed population of about three million, healthy labor was at a premium.

Information about tuberculous disease or previous treatment at a sanatorium or dispensary should be made compulsory for all persons entering industry. This is the practice at military boards and there appears no legitimate reason why this should not be incorporated into the civilian industrial life of the country. Such a measure would ensure the control of infection in the interests of the health of the community. Naturally, such a course will occasion opposition. It will be argued that this represents an encroachment on the freedom of the individual; however, freedom would be an intolerable institution if it permitted an individual indiscriminately to infect with disease his fellow creatures.

An extremely strong case can be made out in view of the recent extension of the defense orders making the treatment of scabies compulsory in the interests of national health. The extension of such a defense regulation to incorporate tuberculosis should prove a relatively simple legal measure.—Some reflections on the Tuberculous in Industry, Bertram Mann, M.B., Tubercle, March 1942.

MASS RADIOSCOPY IN FACTORIES*

Much has been written lately concerning the value of mass radiography of the chest, and reports, among others, of investigations into the pulmonary pathology of Australian recruits, British sailors and Uni-

versity College Hospital students are available, but so far little has been done in this country with the ordinary unselected civilian population. Anyone who has felt the urge to conduct such an examination must at once have become conscious of the many difficulties, of which lack of suitable apparatus and the reluctance of the population to submit to examination are the chief. Nevertheless, few of us doubt that these difficulties will soon be overcome.

X-ray screening of the chest was offered to the work-people in two factories, the management allowing this to be done in working hours. In the first, sixty per cent and in the second, ninety-seven per cent came for examination. Of 575 people examined in the first factory, three were found to be tuberculous. Of 795 examined at the second factory, two were known to have phthisis and two others were found to have active disease.—Mass Radioscopy in Factories—To Small Surveys, A. Stephen Hall, M.B., *The Lancet*, Feb. 7, 1942.

WEEDING OUT TUBERCULOSIS*

Commenting on the above article by Dr. A. Stephen Hall, a later issue of *The Lancet* states in an editorial:

"In each factory about 0.5 per cent of the workers had clinically significant tuberculosis. This percentage is lower than that found in similar mass surveys elsewhere, a common figure being between one and two per cent. The question therefore arises whether the examiner sees as much and as truly on the fluorescent screen as on the developed film.

"In this welter of instrumental aid when employers and employees alike have been led to expect surveys which will 'wipe out tuberculosis' it may be well to add a cautionary word. No diagnosis is ever made on a fluorogram; any doubtful or abnormal finding calls first for a full-size radiogram and, should the abnormality be confirmed, a thorough physical overhaul. If the whole method is not to be discredited, and if hardships and misery from faulty diagnoses are to be eliminated, as much thought must be given to the training of personnel as to the choice of apparatus.

"If a worker submits voluntarily to examination he will naturally ask that he and his family are not to suffer financially while undergoing treatment for what, in his opinion, might have healed at work. Tuberculosis is coming to be regarded more and more as a disease of economics."—Weeding Out Tubercle, Editorial, *The Lancet*, March 21, 1942.

*From Tuberculosis Abstracts, September, 1942.

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NEWS NOTES

GOVERNMENT HOSPITAL TO TOPEKA

The War Department recently confirmed the report that a new \$3,000,000 general hospital will be built in Topeka.

The government is negotiating for a 150-acre tract of land southwest of the city on which to build the hospital. It is estimated that the unit will have a 750 bed capacity.

The new hospital will have no connection with the Army Air Base at Topeka, which has its own hospital facilities and personnel.

SEELEY TO ACTIVE SERVICE

Announcement has been received from the office of Emergency Management of the War Manpower Commission in Washington, D. C. that Lieutenant Colonel Sam F. Seeley has been transferred from the Procurement and Assignment Service to active military duty. Colonel Seeley has acted as Executive Officer of the Procurement and Assignment Service for Physicians, Dentists, and Veterinarians since the beginning of this service.

ANNUAL RE-REGISTRATION

Members are warned that the annual registration fee of \$1.00 which was due and payable on July 1, will be delinquent on October 1. If not paid by that time, the penalty

of \$5.00 is then required by law. Notices were mailed out recently to the last known address. If you have not received your notice, please notify Dr. J. F. Hassig, Secretary of the Kansas State Board of Medical Registration and Examination, 905 North Seventh Street, Kansas City, Kansas.

The statutes governing this matter make no provision for exemption; therefore physicians in military service cannot be exempt, and must re-register in the usual manner, as the Board is unable to grant a waiver.

BLUE CROSS

Enrollment in the Blue Cross group hospitalization plan in Kansas during August showed a slight increase over the July enrollment, according to a report by Sam J. Barham, Executive Director of the Kansas Hospital Service Association, Inc.

August enrollment amounted to 1,371 persons as compared with 1,326 in July, bringing the total number of subscribers to 3,235 as of September 1. Fifty-six employee groups are represented. There are thirty-two member hospitals in twenty-five cities and towns in the State.

Since the plan got under way July 1, there have been fifteen hospital admission, ranging from tonsillectomies to treatment for perforated ulcers.

Blue Cross plans now are operating in thirty-three states, with an enrollment of more than 10,000,000 persons. Enrollment is proceeding at the rate of more than 200,000 a month.

The states covered by the Blue Cross plan are as follows: Nebraska, Iowa, Minnesota, Wisconsin, Michigan, Ohio, Illinois, North Dakota, Texas, California, Kentucky, Tennessee, Mississippi, Alabama, Georgia, North Carolina,

ANNOUNCING THE TWELFTH ANNUAL CONFERENCE OF THE OKLAHOMA CITY CLINICAL SOCIETY

October 26, 27, 28, 29, 1942

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- | | |
|--|---|
| DR. ISAAC A. BIGGER, Surgery, Medical College of Virginia. | DR. DONOVAN J. McCUNE, Pediatrics, College of Physicians and Surgeons, Columbia University. |
| DR. GEORGE M. CURTIS, Surgery, Ohio State University Medical School | DR. FRANK J. NOVAK, JR., Otolaryngology, Chicago, Illinois. |
| DR. F. H. EWERHARDT, Physical Therapy, Washington University School of Medicine. | DR. ALBERT O. SINGLETON, Surgery, Medical Department, University of Texas. |
| DR. FREDERICK H. FALLS, Obstetrics, University of Illinois College of Medicine | DR. TOM D. SPIES, Internal Medicine, University of Cincinnati College of Medicine |
| DR. CHARLES C. HIGGINS, Urology, Cleveland Clinic. | DR. HOWARD C. TAYLOR, JR., Gynecology, New York University of Medicine. |
| DR. SARA M. JORDAN, Internal Medicine, Lahey Clinic | DR. WILLARD O. THOMPSON, Internal Medicine, University of Illinois Medical School |
| DR. JOHN ALBERT KEY, Orthopedics, Washington University School of Medicine | DR. EUGENE F. TRAUB, Dermatology, Post Graduate Medical School, Columbia University |
| DR. BYRL R. KIRKLIN, Roentgenology, Mayo Foundation, University of Minnesota | DR. JAMES E. PAULIN, President-Elect, American Medical Association, Atlanta, Georgia |
| DR. ANDREW W. McALESTER, III, Ophthalmology, Kansas City, Missouri | |

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COMMISSIONS GRANTED

The Kansas Medical Officers Recruiting Board has announced that the following doctors of medicine have been commissioned by the Board as of August 18. The list is in addition to the ones published in the June and the August issues of the Journal.

NAME	ADDRESS	RANK
Gordon B. Sekavec, Athol.....		First Lieutenant
Raymond H. Huges, Manhattan.....		First Lieutenant
Lee Emerson Rook, Kansas City.....		First Lieutenant
Calvin W. Henning, Ottawa.....		Captain
Preston E. Beauchamp, Sterling.....		Captain
James G. Gaume, Ellinwood.....		First Lieutenant
Willis L. Beller, Topeka.....		First Lieutenant
Glenn S. Rost, Halstead.....		Captain
Donald M. Diefendorf, Waterville.....		Captain
Louis G. Graves, St. John.....		First Lieutenant
Clifford B. Newman, Pittsburg.....		Captain
Edward J. Schulte, Girard.....		Captain
Kenneth E. Conklin, Abilene.....		Captain
Herbert L. Songer, Lincoln.....		First Lieutenant
George L. Norris, Wichita.....		First Lieutenant
William H. Walker, Eskridge.....		First Lieutenant
Bernard Goldblatt, Kansas City.....		Captain

The Dental member of the Board, Captain Kenneth I. Cochran, has been withdrawn from the State office and is being transferred to Leavenworth.

MINUTES

The following are the minutes of the Society Committee on Child Welfare which was held in Topeka on August 30, 1942. Members of the Committee present were Dr. Paul E. Belknap of Topeka, Chairman, Dr. E. G. Padfield of Salina, and Dr. Fred Mayes of Topeka. Jane Skinner, Assistant Executive Secretary, and Clarence G. Munns, Executive Secretary, were also present.

"Discussion was had concerning the possibility of Dr. Mayes serving as secretary of the Committee inasmuch as the Committee felt many advantages would be provided in his assisting in that manner. Dr. Mayes stated that he would be glad to assist in that capacity, and thus he was so appointed.

Decision was made that this year's projects of the Committee shall be assigned individually to the members of the Committee and that each member would be asked to study and execute the projects assigned to him in conjunction with the approval and recommendations of the Committee.

The following matters were also discussed:

The possibility of the Committee assisting in the preparation of budgets and programs for the Division of Child Hygiene of the Kansas State Board of Health. A suggestion was made that the contemplated budgets and programs of this department be forwarded to the members of the Committee each year in advance of their adoption in order that the suggestions of the Committee might be obtained. Dr. Mayes stated that his department would be very glad to cooperate in this manner.

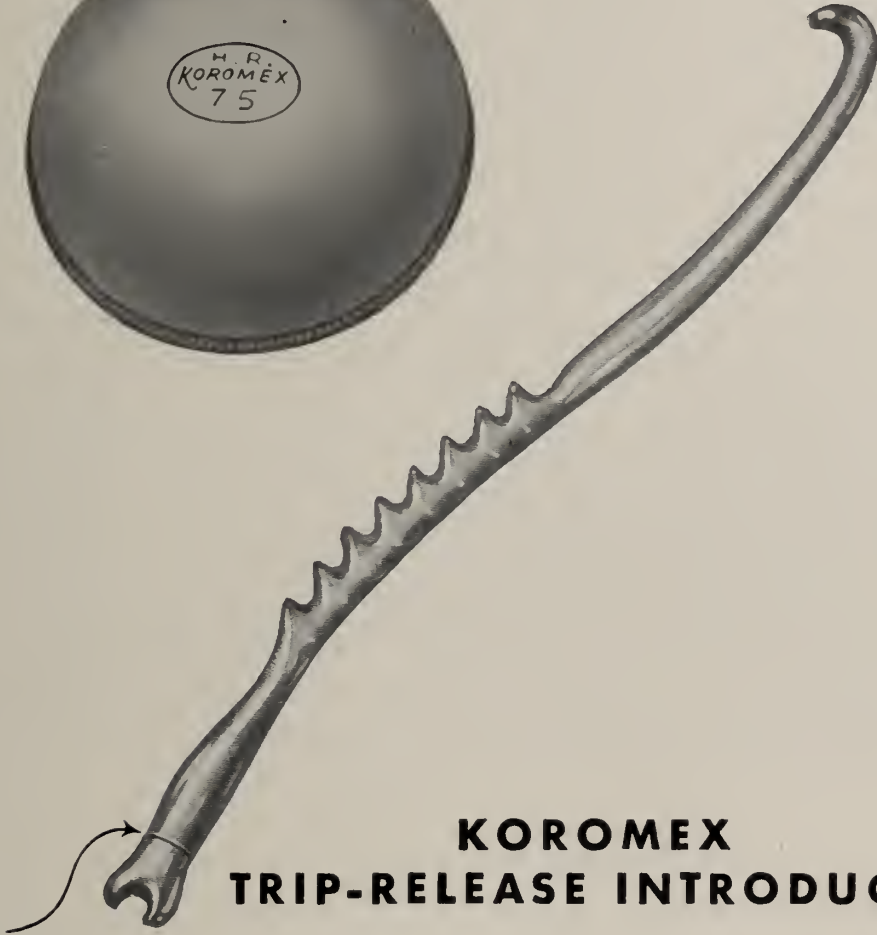
Dr. Mayes asked whether the Committee would be willing to serve as an advisory committee to his Division. The Committee stated it would be willing to do so if that arrangement meets with the approval of the Kansas State

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Board of Health. A report was made concerning the plans the Kansas State Board of Health has for the passage of a compulsory vaccination and immunization law. The Committee offered any help desired in this connection.

Suggestion was made that Dr. Mayes prepare recommendations concerning needed changes in Kansas quarantine regulations and that such be forwarded to the Committee for consideration.


Dr. Mayes was asked to meet with representatives of the Kansas Legislative Research Council for discussion of the health features of the contemplated Kansas School Code Law.

A report was made that the Committee is cooperating with the Kansas State Nutrition Committee and that it is believed satisfactory progress is being made in that regard.

Decision was made that a bulletin should be forwarded to the other members of the Committee asking their opinions concerning the use of tetanus toxoid and whether they believe the procedure is sufficiently substantiated to enable the Committee to recommend it for general use by Kansas physicians. It was the opinion of the Committee, however, that the Kansas State Board of Health should not include this procedure in its immunization program at the present time.

Suggestion was made that the Division of Child Hygiene of the Kansas State Board of Health prepare information concerning child mortality in Kansas, for consideration by the Committee.

A report was made concerning the presentation of exhibits of child health by the Kansas State Board of Health.



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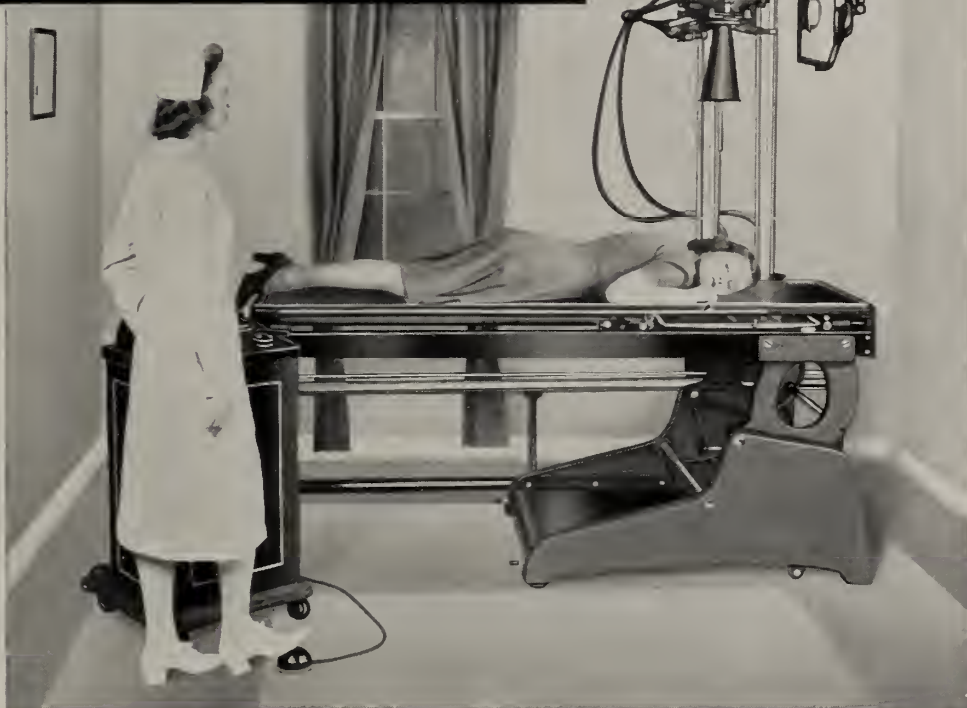
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It was the opinion of the Committee that this is a worthwhile activity and that efforts in this direction should be furthered in every way possible.

Dr. Mayes presented a report concerning the presentation of public health information at Teachers' Institutes and at Teacher College summer courses. The Committee felt that programs of this kind can be particularly helpful and offered its assistance therein in any way desired.

Decision was made that plans for post-graduate courses, to be presented by the Committee, should be coincided with other plans being considered at the present time by several other Society committees.

Discussion was had concerning the possibility of the Committee assisting in the publication of a pamphlet containing concise and helpful information for laymen on subjects such as nutrition, immunization, preventive medicine, etc. Approval was given for the preparation of a pamphlet of this kind.

It was agreed that the Committee should attempt to cooperate closely with the child health activities of the Kansas Parent-Teachers Association and the Kansas Teachers Association.

The Committee decided that no action would be taken this year on the item pertaining to modification of measles, contained in the recommended program for the Committee.

The Kenny method of treatment of poliomyelitis was discussed and it was agreed that no action should be taken on this subject until after the meeting of the Kansas Academy on Pediatrics.

Adjournment followed."

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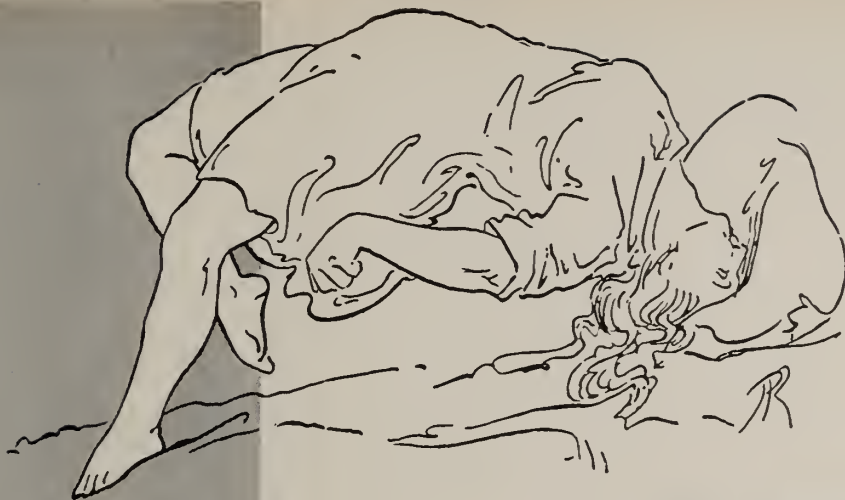
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*TRADE MARK REG. U. S. PAT. OFF.

1. McEachern, D.: Canadian Med. Ass'n. J., 45:106, 1941.

2. Lennox, W. G.: Med. Ann. Dist. Col., 10:461, 1941.

Detailed literature upon request.

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COUNTY SOCIETIES

The Cherokee County Medical Society held a business meeting in Columbus on August 25.

The Lyon County Medical Society entertained with a picnic in Emporia on August 4.

The Mitchell County Medical Society held a meeting in Beloit on August 16. Mr. R. S. Hass, County Welfare Director discussed indigent care in the county for the coming year. Dr. Hugh A. Hope of Hunter was elected Secretary-Treasurer of the society to fill the unexpired term of Dr. R. E. Bennett of Beloit who is entering the armed forces.

The Shawnee County Medical Society held a meeting in Topeka on September 7. Dr. W. C. Menninger of Topeka spoke on "Emotional Reactions Created by the War."

The Sedgwick County Medical Society held its Sixteenth Annual Golf and Skeet Tournament at Crestview Country Club and the Wichita Gun Club in Wichita on September 18.

The Wyandotte County Medical Society held its first fall meeting in Kansas City on September 1. Dr. L. B. Gloyne of Kansas City spoke on "Some Techniques in Military Hygiene which can be used in Civilian Life." At a recent

meeting of the organization, Dr. D. Medearis of Kansas City was elected as President to fill the unexpired term of Dr. T. J. Sims who has recently joined the armed forces.

DEATH NOTICES

Dr. John W. Darlington, 88 years of age, died on August 21, at his home in Valley Falls. Dr. Darlington was graduated from the College of Physicians and Surgeons of Baltimore, Maryland, in 1887 and had practiced in Kansas more than fifty-five years. He was an honorary member of the Jefferson County Medical Society.

Dr. William Kirk Frost, 53 years of age, died on August 31, at his home in Atchison. Dr. Frost was graduated from the Creighton University School of Medicine in 1914. He was a member of the Atchison County Medical Society.

MEMBERS

Dr. J. B. Anderson formerly of Centralia is now located in Valley Falls.

The American College of Chest Physicians announced that Dr. F. C. Beelman of Topeka, Secretary of the Kansas State Board of Health, has recently been made an Associate Member of that College.

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FRACTURES & TRAUMATIC SURGERY—Two Weeks Intensive Course will be offered starting September 21st. Informal Course available every week.

GYNECOLOGY—Two Weeks Intensive Course will be offered starting October 5th. Clinical and diagnostic Courses every week.

OBSTETRICS—Two Weeks Intensive Course will be offered starting September 21st. Informal Course every week.

OTOLARYNGOLOGY—Two Weeks Intensive Course will be offered starting September 14th. Clinical and Special Courses every week.

OPHTHALMOLOGY—Two Weeks Intensive Course will be offered starting September 28th. Five weeks Course in Refraction Methods starting October 19th. Informal course every week.

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Dr. O. J. Hartig formerly of Downs is now resident surgeon in the Kansas City General Hospital.

Dr. C. E. Long has recently returned to Norton from Chicago where he has been doing post graduate work in surgery at the Cook County Hospital.

Dr. W. E. McKinley, formerly of Jewell, is on the medical staff of the Osawatomie State Hospital.

ANNOUNCEMENTS

The American Hospital Association will hold its annual meeting and War Conference in St. Louis, Missouri, on October 12-16, 1942. The annual meeting will be based primarily on the consideration of war problems which face the hospitals of the country today and these subjects will be discussed by leading speakers from the United States Public Health Service, government and the medical and nursing profession. There will be sections devoted to the following subjects: Accounting, purchasing, administration, hos-

pital-service plan, tuberculosis, nursing, lay-women in service, public education and public hospitals, social service, pharmacy, out-patients, and war problems.

Announcement has been made that the 1942 Clinical Congress of the American College of Surgeons will be held in Cleveland, Ohio, on November 17-20. A daily program of clinics in hospitals will be provided. The following speakers are scheduled on the program: Dr. W. Edward Gallie of Toronto; Major General James C. Magee, Surgeon General of the United States Army; Rear Admiral Ross T. McIntire, Surgeon General of the United States Navy; Dr. Thomas Parran, Surgeon General of the United States Public Health Service; Dr. George Baehr, Chief Medical Officer of the United States Office of Civilian Defense; Dr. Frank H. Lahey, Chairman of Directing Board of the Procurement and Assignment Service and Captain Frederick Hook, M.C. of the United States Navy, who will speak on "Wounds in Combat." There will be a cancer conference and special phases of surgery of the eye, ear, nose and throat. Address communications to Irvin Abel, Chairman, Board of Regents, American College of Surgeons, 40 East Erie Street, Chicago, Illinois.



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* *Laryngoscope*, Feb. 1935, Vol. XLV, No. 2, 149-154
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60

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BOOK NOOK

BOOKS RECEIVED

SYNOPSIS OF PATHOLOGY.—W. A. D. Anderson, M.A., M.D., Assistant Professor of Pathology, of St. Louis University School of Medicine; Pathologist of St. Mary's Group of Hospitals. Published by the C. V. Mosby Company of St. Louis, Missouri. Priced at \$6.00. This book of 661 pages contains 294 text illustrations and seventeen color plates.

ADVANCES IN PEDIATRICS—Editor, Adolph G. DeSanctis, M.D., of the New York Post Graduate Medical School and Hospital, Columbia University of New York, New York, and Associate Editors: L. Emmett Holt, Johns Hopkins Hospital of Baltimore, Maryland; A. Graeme Mitchell, M.D., of the Children's Hospital of Cincinnati, Ohio; Robert A. Strong, M.D., Tulane University of New

Orleans, Louisiana; and Frederick F. Tisdall, M.D., of the Hospital for Sick Children of Toronto, Ontario, Canada. Volume I is priced at \$4.50. Published by the Interscience Publishers, Inc., of 215 Fourth Avenue of New York, New York. The book contains 306 pages.

CLINICS, SYMPOSIUM ON BURNS AND SHOCK—Edited by George Morris Piersol, M.D., Professor of Medicine, Graduate School of Medicine of the University of Pennsylvania of Philadelphia, Pennsylvania. Published by the J. B. Lippincott Company of Philadelphia, Pennsylvania. Bound or paper backed bi-monthly published for the price of \$12.00 per year. This volume of 264 pages published in June is volume one, number one.

PHYSICIANS' REFERENCE BOOK ON EMERGENCY MEDICAL SERVICE, A Compilation, Chiefly from Medical Literature, Presenting the Practical Experience and Lessons Acquired in Handling Civilian War Casualties—Published by E. R. Squibb and Sons, New York.

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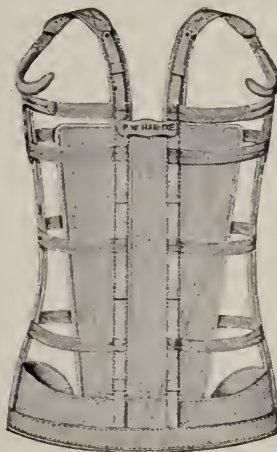
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KANSAS MEDICAL ASSISTANTS SOCIETY

A meeting of the Executive Committee of the Kansas Medical Assistants Society was held in Topeka on September 6. A provision was introduced to amend the State constitution as follows: Chapter 111, of Section 111, will read: "That the Annual nomination and election of State Officers will be held at a meeting immediately following the luncheon of the main day of the meeting."

The treasurer reported a balance on hand of \$154.44.

A letter of resignation was received from Marie Schwartz, Councilor of the Fifth District, who is entering the United States Navy Nursing Corps. Barton County was advised

to appoint a new Councilor for that District, to fill Miss Schwartz' unexpired term of office.

The motion was made that names of members entering the armed forces be placed on a society honor roll.

The Shawnee County Medical Assistants Society held its first fall meeting in Topeka on September 3. Dr. R. E. Pfuetze of Topeka, formerly of Porto Rico, showed moving pictures of Porto Rico and discussed the country and the hospital facilities there. Mrs. Martha Cox, President, announced that one-third of the membership of the Society had joined the Kansas Blue Cross, as of September 1. The next meeting will be held on October 5.

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Volume XLIII

OCTOBER, 1942

Number 10

INTRATHORACIC GOITER^{*}

Charles W. Mayo, M.D.

Rochester, Minnesota

INTRODUCTION

There is practically nothing which concerns the classification, theoretic etiology, symptomatology, preoperative preparation, types of surgical technic, postoperative care, and so forth, ad infinitum, of the various types of goiter that has not been talked and written about exhaustively by men interested in the medical and surgical problems of thyroid disease. The above statement is made with no derogatory intent, because only by such evident interest can the status quo be maintained or, still more preferably, can progress be made in this field.

My reason for discussing the subject of intrathoracic goiter is to present personal impressions of what seems to be important from the surgical viewpoint. Personal opinion, after all, is what the audience gets in any presentation of this nature.

WHAT IS AN INTRATHORACIC GOITER?

The thoracic aperture is on a plane extending from the top of the first thoracic vertebra to the superior part of the manubrium, spreading laterally along the top of the first ribs. Thus, any goiter which projects below this point becomes essentially partially intrathoracic. It may rise above the plane on the patient's swallowing; practically, this is of importance as an indication that surgical removal will be technically easier. Once it has progressed to this stage, unless it is removed, the tendency, because of the shape of the upper part of the thorax just below the aperture, is for the goiter to become more and more intrathoracic with the passage of time. "Substernal" is an adjective denoting the anatomic relationship of an intrathoracic goiter. All degrees of size, all varieties of shapes and, within the limits of the upper thoracic cavity, many locations, are assumed by these projecting goiters. Upon these factors will depend the symptoms and signs

of pressure which in the main will be the considerations that bring the patient eventually to the physician.

WHY THE PATIENT SEEKS THE SURGEON

These patients, who finally have sufficient distress to cause them to seek operative relief, come to you or to me, most of them having consulted many another physician previously. They have been advised to undergo an operation before, and for one reason or another have not done so. Their difficulty has not been pain; it has been gradually increasing distress and at long last dyspnea on slight exertion, in part due to interference with the respiratory channels and in part due to vascular pressure.

The large size to which some of the intrathoracic goiters can grow, and the comparatively few symptoms that may develop, are more of a tribute to the adjustability of the human body than to the good sense of some of these patients. In this special sense, it is perhaps unfortunate that pain cannot be added to the early symptoms of many hazardous conditions to which the body may fall heir.

Let us not concern ourselves herein with small substernal or intrathoracic projections of the pathologic thyroid gland in which the problem is relatively simple to one interested in surgery of this part of the body. Rather, let us try to confine the discussion to those cases in which half or more of the enlargement is in the upper part of the thorax and in which, preoperatively, the lesion seems removable, but at the time of operation and postoperatively is found to tax all the facilities of the surgeon.

PREOPERATIVE CONSIDERATIONS

It is trite to say that one should be sure about the diagnosis of intrathoracic goiter before operation. In spite of all the diagnostic means available, however, there are instances in which it is not possible to state preoperatively that substernal or intrathoracic goiter is the diagnosis. As a matter of fact, instances are on record in which there seemed to be no question as to such a pathologic condition, but operation proved otherwise. In other words, it is well always to keep in mind the possibility that

^{*} Presented at the 83rd Annual Session of The Kansas State Medical Society, Wichita, May 14, 1942.

something may be found which is different from that for which the operation is undertaken.

To illustrate this point, let me cite three cases in which I have operated. In the first the patient had a mass which was very firm, just palpable below the right lower pole of the right lobe of the thyroid gland; it was impossible to ascertain whether there was attachment to the gland itself. Roentgenologically, it was substernal; it pushed the esophagus to the left, the trachea anteriorly and to the left, and moved on the patient's swallowing. On surgical exploration it proved to be a neurofibroma and when it was removed, later, a posterior approach was required.

In the second case, a patient had a large mass that was palpable just above the right clavicle; the mass seemed to be attached to the thyroid gland; it was substernal and intrathoracic; some bony changes were present, suggesting possible parathyroid pathology, but this was not certain. On surgical removal, the lesion proved to be a tumor of a parathyroid gland which weighed 101 gm.

The next case occasioned considerable debate, despite repeated palpation and roentgenoscopic examinations. There was marked stridor and dyspnea and the mass presented in the upper part of the thorax on the right. When surgical exploration was carried out, an aneurysm of the subclavian artery was found. Members of the patient's family were informed of the findings, and the patient returned home with nothing having been accomplished for the relief of symptoms. A month or two later I received a telegram from a surgeon who is a friend of mine in which he inquired what our diagnosis was. I wired back, "Aneurysm." The next day another telegram was received from the surgeon, in which he said, "Operated; diagnosis correct; patient succumbed to hemorrhage."

It is well to re-emphasize the value of the making of anterior, posterior and lateral roentgenograms, as well as fluoroscopic examination, in cases in which intrathoracic goiter is suspected, not only to try to establish a diagnosis but also to determine the exact displacement of the trachea.

ANESTHESIA

There is no single type of anesthesia which is perfect in all cases of intrathoracic goiter. One familiar with many types of anesthesia and their administration, however, can weigh the various factors involved and approach perfection for the individual patient.

Local anesthesia not only may suffice but also may be preferable in some instances; a general inhalation type may be selected as best suited in others, Ether, nitrous oxide, cyclopropane and ethylene all

have their advocates. Combinations of anesthetic agents occasionally are used to advantage; for instance, induction of anesthesia with an inhalation agent may be assisted by intravenous administration of a small initial dose of pentothal sodium.

When tracheal compression or deviation exists, or when one is to deal surgically with an intrathoracic goiter, difficulty can be anticipated, and if general inhalation anesthesia has been selected, an intratracheal catheter not only can be used but, furthermore, should be used to avoid further obstruction to the airway in the necessary mobilization of the intrathoracic glandular tissue. My own preference of inhalation anesthesia in these cases is cyclopropane, but only when administered by one thoroughly familiar with its dangers as well as its advantages. On the other hand, personally, after considering the various factors which influence choice of anesthetic agents, if I feel that cervical block and local anesthesia will be acceptable, I will use it, for experience has taught me the better to interpret the signs that may indicate undue tracheal compression during manipulation or the immediate signs of tension on the recurrent laryngeal nerve. The immediate notation of such reactions to me is of vital importance: it permits me to retract the last false move or to avoid the next false move.

OPERATIVE TECHNIC

There are about as many variations in technic as there are surgeons doing thyroid surgery. In the surgical treatment of intrathoracic goiter, however, there are certain general principles which, it is agreed, are helpful:

First, an adequate and properly placed incision should be made; that is, one long enough and low enough for the surgeon to work in freely. More consideration is paid to doing the operation than to the cosmetic result, although the latter point is not to be neglected.

Second, the ribbon muscles should be transected unilaterally or bilaterally, when indicated, to fulfill the principle of adequate exposure.

Third, knife, scissor and blunt dissection of the glandular tissue to be removed should be carried out to the limits possible

Fourth, the superior pole should be freed and the superior thyroid vessels should be ligated so that the intrathoracic portion of the lesion can be more easily elevated by traction.

Fifth, traction and dissection should be continued. From this point on, finger dissection will accomplish most in the lines of fascial planes and still keep surgical activity close to the glandular projections.

Sixth, few instances of intrathoracic goiter will

require splitting of the sternum or disarticulation of the clavicle; but when it is absolutely necessary either can be done.

Seventh, the cough may be serviceable in helping the surgeon to elevate the intrathoracic portion of the lesion.

Eighth, extreme care should be taken, as in any operation on the thyroid gland, to avoid injury to the recurrent laryngeal nerves.

Ninth, drainage should be established when large cavities are left, and should be maintained according to each individual indication.

Tenth, before closure of the incision, induced straining to ascertain bleeding points is important. Hemostasis that is accurate will obviate night work and induce good healing.

POSTOPERATIVE CARE

Postoperative care of the deep intrathoracic goiter that was difficult to remove may present no problem whatsoever, but one will do well to be prepared for any eventuality. The immediate care after operation has as its objective the prevention of complications. My routine calls for the administration of high concentrations of oxygen, either by tent or mask, unless otherwise ordered. There should be available the apparatus for the administration of eighty per cent helium and twenty per cent oxygen, in case obstruction to respiration should for any reason develop. For the first two or three days these patients should have constant and experienced nursing care.

The first dressing applied after operation, as well as succeeding dressings (until nausea and vomiting have subsided, if unfortunately they are complications), should have a covering of some waterproof material, placed so as to avoid vomitus from coming in contact with the wound and causing infection. All dressings should be most carefully applied, as in any postoperative case. Drains are to be removed as indicated from each patient, on the basis of the quality and type of drainage which is present, and the temperature and pulse rate. It is better to leave drains in position for a couple of days too long than to remove them too early.

If, for any reason, it is found necessary to re-open the wound, after the purpose of the secondary procedure has been accomplished, it may be found advantageous to place seventy-five grains (4.9 gm.) of sulfanilamide powder in the wound and to resuture the skin with interrupted stitches.

COMMENT

The preoperative preparation and speculation, the operative procedure itself and the postoperative care present interesting problems to be met and solved in each case of intrathoracic goiter; no two are

alike. The gratification to the surgeon who has been able successfully to relieve the dyspnea, choking and distress which some of these patients have is sufficient compensation in itself for the difficulties which are encountered.

THE INTERRELATIONSHIPS BETWEEN MEDICINE AND PSYCHIATRY

FUNDAMENTALS OF PSYCHIATRY I

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Psychiatry is the specialized branch of medicine which is concerned with the study, the diagnosis, and the treatment of those illnesses of mankind which are characterized by conspicuous mental symptoms. Such a definition, however, is not sufficiently broad to include "the psychiatric point of view." By the psychiatric point of view we refer to an interest in and understanding of all of the activities and behaviors and interests of the human race. Just as the internist is interested in how the heart functions in health, so is the psychiatrist interested in how the total person functions in health. The practice of psychiatry used to be limited to the groups secluded in stone buildings on the edge of the village known as "insane asylums," but now a psychiatric interest extends into the office of the private physician, into our educational system, into our law courts, into our correctional institutions, and most important of all, into our general hospitals. The psychiatric point of view has become a necessity for every physician and every nurse, if they are to completely understand any sickness in any individual.

Every physician and every nurse is confronted daily with psychiatric problems, problems that require a psychiatric knowledge for their understanding. For example, the very sick individual with pneumonia may develop a delirious reaction which presents a more difficult problem of treatment than his lung condition. In hyperthyroidism one is often perplexed with the problem of restlessness, sleeplessness, and anxiety. The reaction to pain varies with the individual so widely that only with an understanding of his psychological makeup can it be interpreted. The average physician's daily practice includes those persons with functional heart difficulty, the person whose mind centers around some part of his gastrointestinal tract—the dyspeptic, the choleric, the constipated, the flatulent, and a host more. None of these individuals ordinarily come to the psychiatrist,

or even need to do so, but they do come to the general physician or to the specialist. As a result of the treatment they receive these individuals either obtain gratification and relief, or start the rounds from doctor to doctor, or even worse, resort to the charlatan. Without a psychiatric point of view on the part of their physicians, these patients almost invariably follow the latter route.

Immediately when one begins to talk about psychiatry he needs a term to describe the individual from the psychiatric viewpoint. When the psychiatrist speaks of John Doe, he refers not merely to his mind or his intelligence or his emotions, but to all of these together, along with his skin, his muscles, his heart, his intestines, and the way they function. It is even more than just the physical structure, this term must embrace all his attributes—his loves and his hates, his play and his work, and his reactions to all those about him. To include all this in one word the psychiatrist uses the term "personality" and by it he means all that anyone has been, all that he is, and all that he is trying to become.

Thus, when a man functions in any way—physically, as in motion; physiologically, as in digestion; psychically, as in thought—it is an expression of his personality. The psychiatric viewpoint encompasses the observation, the correlation, the purpose, and the motive of every expression of any personality. This viewpoint covers a far wider horizon than the actual field in which the psychiatrist practices, because it applies to all human beings. His major work is limited to those individuals in whom the psychic expression of the personality has become warped or distorted or perhaps even wrecked. But the psychiatric point of view must permeate all the fields of medicine, and the successful physician or nurse, whether he wishes to or not, must in some degree have a psychiatric viewpoint.

PSYCHIATRY IN RELATION TO THE TOTAL FIELD OF MEDICINE

At the present time the more keen and alert leaders in the fields of medicine and nursing are aware of the necessity for groundwork and orientation in psychiatry. There is an increasing awareness also among the practitioners of medicine of the psychic component in all disease. This interest is still very limited, but it is definite and it is growing. One may understand the present point of view in light of the evolution of medical knowledge.

Going back only to the Middle Ages, we find that medicine was dominated by a cloud of spiritualism and religiosity, when man was a prize sought after by the demons who waged a battle with the Lord for his possession. The priest played the role of physician since only the spirit and the soul mattered, and the

body needed chastisement and torture. Then followed the struggle through the Renaissance and Reformation with the spectacular materialistic discoveries of Harvey, Koch, Pasteur, Ehrlich, and many others. The result was to discredit the existence of all phases of illness that could not be viewed in some kind of scope, or measured or tested in some quantitative fashion. These anatomical, chemical, and mechanical advances have continued, and until thirty years ago, did so proportionately much faster than those in the psychological field. But the pendulum which swung so far to the right and then to the left is beginning to approach an equilibrium again, where both physical and psychic factors are viewed with equal scrutiny.

Sooner or later, most of us have moments when we speculate as to what may be the purpose of disease. What is the ultimate cause of disease? Why should the human race be cursed (or blessed) with it? One must necessarily come to the conclusion that from this viewpoint all life is a struggle against that irresistible, inevitable ending—death. Every activity in which man participates is in some way or other related to this struggle against death. As this threatening specter appears, even on the horizon of an individual's life, he reacts to it, either by a fight against it, a flight from it, or an attempt to find some medium ground—even though safe only temporarily—a compromise. His reaction is not in terms of liver alone, or bone, or muscle, or mind; he functions as a complete unit which defies any separation into parts or segments. The older conception of a division into brain-mind-spirit and body-soma-organism does not hold. Every reaction and every function of the individual in health and in disease is a total one—a "psycho-somatic" one.

Much as we should like to believe differently, we know that only a minority of physicians and nurses make practical use of such a viewpoint. The chemical and physical advances have given us a somewhat practical but inadequate attitude which tends to limit our diagnostic procedures to physical measures, to attempt explanations only in physiological and chemical terms, and to rely for treatment on chemical and mechanical means. But every practicing physician and nurse recognizes intuitively that the practicality in sticking to materialistic and physical conceptions is only a part of the truth. Even though he can not reduce this particular imponderable to a ponderable, and for practical reasons treats his patient for a specific organ disease—for instance of the gall bladder—he knows that the man functions in only a small part through his gall bladder. The organ is only the focal point of a struggle, which is expressed also in part through the autonomic nervous

system, through the endocrine glands and the emotions—in short, through every body system. In this particular example of gall bladder disease, the intuitive judgment of the physician is shown in the three well known alliterative terms often associated with it, "fair, fat, and forty," each of which refers not to the pathology of the gall bladder, but to the total reaction of the individual.

We may agree that man's struggle for life, liberty, and the pursuit of happiness (or sadness!) is always a total organism reaction. Sickness and disease represent a phase of this struggle in which the individual is attempting to fight (though unsuccessfully) against some phase of his environment. Or it may represent a flight from some threatening force. In this reaction called disease, whether it may be a fight or a flight, we can readily see that there may be varying degrees of emphasis on either the physical or the mental expression. But all disease is included in this description, even though in some instances the emphasis is chiefly on the psyche (the mind) and in others, chiefly on the soma (the body); never is it entirely one or the other.

While it has been stated that the field of the psychiatrist is limited, nevertheless, it is not generally recognized that more than half of the hospital beds in the United States are devoted to patients with mental illnesses. Even more surprising is the fact that less than five per cent of physicians are concerned with this field of medicine, and less than ten per cent of graduate nurses are engaged in this branch of their profession. When we add to this total of frankly psychiatric cases, the fifty per cent of every physician's practice which is composed of illnesses or disorders in which he can find no physical cause, one can understand the statement that psychiatry is probably the broadest field in medicine.

PSYCHIATRY IN RELATION TO THE NORMAL

Most of us pride ourselves on being "normal" individuals, not stopping to analyze what we mean by "normal." We recognize that the concept of disease is based on an understanding of health, and yet when one talks about a "normal" individual either physically or mentally, he talks about a hypothetical individual. In some instances, "normal" means "average"; in some instances, it means efficiency; in some instances, it means majority. Specifically, we know that the majority of people have deviated septums. Are they then abnormal? A large number of individuals have nearly flattened arches in their feet, without functional difficulty. Are they abnormal? In the mental sphere one meets even greater difficulty in trying to define "normality." One man mourns for a day following the death of his wife; another man mourns a week; a third man mourns a

month; another mourns indefinitely. What is normal? One man likes red wine; another likes white wine; another likes sparkling wine; and none of the three will have any other sort. Which is normal?

One might elaborate this theme indefinitely, and yet what has been said is sufficient to indicate that our reactions, our struggles, our work, our loves, our hates are determined by many factors—so many, that no two of us are identical. We differ not so much in the qualitative factors of our personality as in the varying quantities or modifications of those characteristics present in all of us. For instance, every man has some love for himself; most men have some love for other people or things, but it is the quantity of this love that differentiates. These quantitative differences make the concept of normalcy intangible and of relatively minor significance. One may ask then if normalcy isn't important, does psychiatry have any thing to do with me as a healthy and ordinarily happy individual?

PSYCHIATRY IN RELATION TO THE HEALTHY INDIVIDUAL

It is essential at the outset in the study of psychiatry to clarify one's conception that all mental disorders are not included in the group which the public calls "insane," and the group referred to as "neurotic"—those unfortunate individuals whose psychological jams express themselves in morbid fears or physical complaints. The same psychological devices which operate in these individuals also operate in a different quantitative degree in those of us who feel and act and appear as healthy individuals.

In other words, it is helpful to start the study of psychiatry by recognizing that in each of us there are eccentricities, peculiarities, idiosyncrasies, and most of us are blind to these in ourselves. But we will all admit periods when we are irritable, perhaps unhappy; other periods when we are a little "low" in spirits; moments when we are temporarily "mad" and consumed with hate. Each of these states is an evidence of transient mental ill health, a minor psychological jam. In this connection I like to use the analogy given by my brother in "The Human Mind," the comparison of man with a fish. In a sense, we are all "poor fish," swimming around in the sea of life, trying to avoid those bigger fish which might eat us, trying to find some light, air, freedom, and at the same time always nibbling at the tempting hooks which dangle around us. We see some of our brother and sister fishes who get away with the whole bait; we don't understand how they did it, but are tempted to try it, too, depending on our past experiences. All of us at times grab hold of a bait and make a dash and often get away with it; as long as we succeed we are comfortable, happy and regard

ourselves as "normal" or healthy. But at other times we are brought to an abrupt stop at the end of the line. We are "hooked"; we fight or we may take flight, but always we struggle. We are aware of this struggle in various forms—usually unhappiness. It may be worries or fear or anxiety or excitement. Sometimes it takes the form of pain or physical distress. Rarely we blame ourselves; more often we blame fate or some other person or situation (the hook). Sometimes we are able to escape by dislodging the hook, though like the fish, we often start immediately after another one. Sometimes some of us are pulled out of the water into a strange environment where nothing seems right. We feel ill at ease we are unhappy—we can't function. Curiously enough, throughout the entire struggle none of the other fishes seem to understand; they may watch and may be sympathetic toward our struggle though the more we fight, splash, and splatter, the less they seem to comprehend. When we're hooked and landed then we become "cases" and some one else must take us in charge.

POPULAR MISCONCEPTIONS REGARDING MENTAL ILLNESS

Not only is it desirable at the outset for the student to understand the psychiatrist's concepts of personality, disease as a total organism reaction, normalcy, and mental health, but it is equally desirable to correct the more common popular misconceptions regarding mental ill health. In part because of historical influences, in part because of lack of adequate means of education, and in part because of the comparatively recent developments in the field of psychiatry, there are a great many misconceptions regarding mental illness among even very intelligent people. Paradoxically, many of these misconceptions are held by members of the medical or nursing profession, the explanation of which lies entirely in the fact that most of us had an inadequate training in the field of psychiatry in medical school or in the hospital. It seems advisable to clarify the more common of these misconceptions.

1. The misconception that mental sickness means that a person is irrational or beyond understanding, and that the sayings and acts of the mentally ill are nonsensical and incomprehensible. From the point of view of modern psychiatry the term "mental sickness" can be applied to the "normal" individual during a period of temper outburst, or during a period of depression, or a period of intoxication. In other words, when functional deviations from the individual's usual pattern of reaction are present, one may assume that he is temporarily—even though mildly—mentally ill. As all of us are subject to physical illnesses, so are we all subject in some degree at some

times to "mental illness." Again the quantitative difference is more important than any qualitative difference. On the other hand, comparatively few, even of those individuals committed to state mental institutions, are necessarily irrational or beyond understanding. Certainly only a minority of them make nonsensical or incomprehensible remarks.

2. The misconception that hospitalized mentally sick people all rave and yell and run about and are violent. Such naivete, such ignorance is frequently exhibited by very intelligent friends of the psychiatrist who have that idea about patients in his hospital. By his own blind spot, the average layman so obscures his own eccentricities and queernesses that it is something of a shock to him to learn that approximately fifty per cent of the patients in any psychiatric hospital present no abnormalities apparent to the superficial observer. Likewise, it is difficult for him to comprehend that approximately not more than five per cent of all hospitalized psychiatric patients are disturbed or violent, or rave. Again, one needs only to be reminded that all of us under certain circumstances of intense anger or fear may "rave" or "yell" or run about and become "violent."

3. The misconception that mental sickness means that a person is dangerous to himself or others. This misconception is something of a popular superstition. Anyone who is "crazy" is supposed to be dangerous. In very rare instances, homicides are the direct result of mental sickness, but such events are exceedingly rare in mental institutions. If one limits his consideration to the severe illnesses called psychoses (which usually necessitate hospital care), probably not more than one person in fifty is likely to make any physical attack on another person. Not one in two hundred is likely to have conscious murderous intent.

In one class of illnesses, namely the depressions, the danger of self-destruction is a very great one. Approximately one-half of the 22,000 suicides that occur each year in the United States are individuals with this type of illness. In these instances, the family, although holding the popular misconception as stated, fails to apply it when one of their own members becomes ill. On the other hand, depressions represent approximately fifteen per cent of all mental illnesses committed to state hospitals. The great majority of individuals with other types of severe mental illness are infrequently suicidal.

4. The misconception that mental illness comes suddenly, that "something snaps," or that "one suddenly loses one's mind," and that there is no protection against this onslaught. Repeatedly well-informed people tell that at the onset of their ill-

nesses, something seemed to "snap," or "give way." Even more often, it may be the opinion of the intelligent relative that his loved one was "perfectly all right" until two days ago, when suddenly he became delirious and irrational. This misconception is based on the correct conception that mental illness in some instances does progress to an irrational or excited stage over a period of a few hours or a few days. On the other hand, no mental illness ever develops without fertile soil, without considerable preparation, without many preliminary determining factors which have arranged the setting for the final act. The play can't go on without its having first been written, been rehearsed, the stage setting all arranged, the lights turned on, and suddenly the curtain may go up and the acting become apparent, but this is possible only with all the preliminary procedures. Applied to mental illnesses, one can always be sure that there have been many abnormalities, many factors and influences which can be ferreted out in the individual's life, which may have been known and have been apparent, but not considered important prior to his "sudden" mental break.

5. The misconception that mental illness is a disgrace to be faced resignedly and with fatalism. Perhaps no other misconception is so widespread as the idea that mental illness in some way or other is a disgrace. This is explained in part by the historical influence of olden times when mental illness was regarded as a bewitchment and treated by stoning the individual or excluding him from the city, or perhaps even more directly, by the relationship between misbehavior and sin. In any event, it is illogical to assume that there is any more disgrace about a malfunctioning mental system than a malfunctioning gastrointestinal system. The Creator didn't make any hypothetical barrier around the mental system which would make it any more impervious or immune to malfunctioning than the respiratory system or the genito-urinary system or any other bodily system. The whole problem is undoubtedly closely bound up with the inherent fear of every individual that he may be a little "queer" or exceptional. To safeguard himself he distinguishes on an emotional basis those individuals so afflicted as belonging to an entirely different strata of mankind than he himself. Every psychiatrist recognizes the unconscious insight of his friends on this particular point and actually becomes bored with the great number of people who in a facetious moment makes some such comments as, "If I don't get over this, I'm going to have to come out there and put myself under your care" or "If this doesn't let up pretty soon, you're going to have me out there among the other nuts."

6. The misconception that mental illness is in-

curable and patients are locked up in asylums for the rest of their lives. Any family who has ever had severe mental illness recognizes the ridiculousness of this misconception. Fortunately, it is the minority of such families, however, who have such an experience, and yet the facts in the case are that approximately forty-five or fifty per cent of those individuals who are so ill as to necessitate hospitalization in a psychiatric institution recover. Again, one should be reminded of the concept of mental illness: that at times we are all "mentally ill," and that very few of us ever have to consult a psychiatrist. Even in the most malignant, the most severe of all types of mental sickness, namely schizophrenia, approximately twenty to thirty per cent of these individuals recover.

7. The misconception that a person is either "sane" or "insane" and that all "insanity" is the same. This statement really includes two misconceptions. "Insanity" is a legal term, rarely used by psychiatrists, and correctly applied only to those individuals who have gone through an examination and a court commitment to a public institution. There is no black line which permits us to separate the sheep from the goats. For practical purposes it is often necessary to decide whether an individual needs hospital care; when he does and can not afford private hospital treatment, he may be declared, after due process of law, "insane." Many people have the idea that all types of mental illness are similar. In a sense they are, and yet to the specialist in this field, it is essential for the sake of treatment to differentiate a good many different types of mental reaction. Just as one may have tuberculosis, cavity formation, bronchiectasis, abscess, pneumonia, all as diseases of the lung, the expert clinician has no difficulty whatever in differentiating the clear-cut pictures of these different disease entities. Likewise, there is little difficulty for the psychiatrist to differentiate between various types of mental reaction, and, for the sake of treatment, to classify them into different diagnostic categories. In some, there are disturbances of the perceptual ability; in some, intellectual difficulties; in some, emotional disturbances; and in others, volitional disorders or misbehavior, and often combinations of these.

8. The misconception that mental illness runs in strains through families from generation to generation. Later the question of heredity and mental disease will be discussed at some length. Suffice it to say at this point, that the hereditary factor in mental illness is far from proved; in fact, there is much skepticism regarding the amount of influence it does exert. In many instances, there is no apparent hereditary influence which can be determined, and the misconception as stated here is grossly wrong.

9. The misconception that mental illness is caused

by emotional shock, injury, physical illness, childbirth, or similar occurrences. It may seem to be a logical conclusion, that when a woman gives birth to a child and immediately thereafter develops a severe mental reaction that the childbirth caused the mental illness. Similarly, it appears to be the case after a blow to the head in some instances; following physical illness; often following emotional shock. A more accurate, scientific concept of this situation is that these various factors act merely as precipitating agents. In other words, of twenty women who may have children only one may have any pathologic psychological response to the situation. We can understand the psychological response, only if we recognize that the one individual must have been conditioned in that direction, and that the additional physiological burden of childbirth was more than her total personality could handle. She broke perhaps in her weakest system. In other words, in every instance where we learn of the supposed "cause" of an illness as being one of those listed above, we always find factors in the personality prior to the particular event which on close scrutiny indicate to the trained observer defects in the personality structure and function. Emotional shocks, injuries, physical illness, and the like, then may provoke the appearance of a mental illness, but in the truer sense of the word, never "cause" it.

10. The misconception that a "nervous breakdown" is a disease of the nerves. The term "nervous breakdown" is used to include everything from headaches to fallen arches; most often it is applied to those functional incapacitated states in which the person is tired, "nervous," weepy, and may have some secondary physical symptoms. But the designation of "nervous breakdown" is a misnomer, since almost never is there any disease or even disorder of the nerves. In almost every instances the sickness is more accurately a mental breakdown with the physical symptoms of insomnia, up-set stomach, tremulousness, fatigability, and others as a part of the personality's expression.

But the term has some dubious advantages. It is one of those tricks of the mind which all of us use to blame our mismanaged emotions on a malfunctioning stomach or a fallen womb. It excuses us from taking any personal responsibility for our failures in solving our psychological problems. For the person who regards mental illness as a disgrace, it is much easier to believe that his "nerves" are out of kilter rather than to be stigmatized by having something wrong with his mind. Furthermore, in the eyes of one's friends, a "mental break" is interpreted as evidence of "craziness," whereas a "nervous breakdown" may even be popular. In any event, the latter

always calls forth the solicitous sympathy of family and friends.

But all of these ideas are only in line with the misconception. The real facts are that a "nervous breakdown" is always indicative of a partial mental breakdown, and those telegraph wires in our arms and legs and body called nerves are only secondarily responding as the result of a disturbance in "general headquarters."

MEDICAL DEFENSE IN KANSAS*

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Topeka, Kansas

It is necessary in these critical times to think of the civilians in many lands who are subject to air raids, to shell fire and to the terrible toll of war, and we must of necessity think of our own safety—even here in Kansas. Although such an emergency may never develop in the midwest, we must prepare for anything which may happen. Should war actually come to Kansas, first-aid, medical and surgical care with hospital facilities must be adequate for such an emergency.

Kansas has been preparing for such an emergency. Major Charles A. Anderson, regional assistant of Protective Service, with headquarters in Omaha, recently wrote a letter of commendation to Governor Payne H. Ratner, chairman of the State Council of Defense in which he says, "There is one outstanding condition in Kansas, and that is the well organized Emergency Medical Division in every town that I have visited . . . the Emergency Medical Division is the most completely organized of any of the other protective services in the civilian defense program within the State."

Before I explain the organization and operation of the Emergency Medical Service in Kansas, I wish to pay tribute to the medical profession who have so earnestly entered into the project. If we have a good organization here, they have made it possible. The Emergency Medical Service, which works in close co-operation with the Air Raid Wardens office, is designed to care for those killed, wounded or shocked in the event of an emergency. It involves working through control centers, so that advance warning of imminent danger may be obtained. It includes ambulance and hospital service. A fund has also been created to pay for such services. Although

*Abstract of radio interview with Dr. F. C. Beelman, Secretary of the Kansas State Board of Health, given over stations WIBW of Topeka and KCKN of Kansas City on August 2, 1942.

the Red Cross, your corner drug store, hospitals, and hundreds of physicians, surgeons and trained workers have important responsibilities, the entire Emergency Medical Service still remains under the jurisdiction of local defense councils and is under the direct supervision of a qualified physician located at the control center, who is the Emergency Medical Service chief.

Suppose, for example, that an air raid should actually occur in this community—or any other community in Kansas where your Service is well organized. The following procedure would be followed:

The commander of the citizens defense corps at the control center, would give the chief of Emergency Medical Services all pertinent information as to location and size of area involved. The chief then sends into action hospital field units who leave with all equipment for the casualty station nearest the scene of disaster. Each field unit is composed of two physicians, two nurses, two nurse's aids or orderlies. Red Cross nurses and trained aides may be a part of this unit. Field units work in close co-operation with hospital staffs.

The whole organization centers about the established hospital and its staff. As many as are needed are dispatched to casualty stations as field units. The ambulance service would be in direct and constant contact with the hospitals, casualty stations and first aid stations, on disaster location.

The casualty station is a very important part of the organization. Large buildings strategically located over the city are designated as casualty stations, swinging into immediate action field units from hospitals organized by the stations. All casualties are brought to these stations from first aid posts. Emergency operations or transfusions necessary to immediately save lives may be done here. From the casualty station all casualties are dispatched to their homes, a hospital, or to an emergency morgue. Records are made in each case.

First aid stations are established nearer to the scene of disaster than casualty stations, as a rule. It is the first aid, that it is possible to administer, at the earliest possible moment. First aid teams composed of a physician, a nurse, and a nurse's aid are sent from the casualty station to establish the first aid post. Due to the fact that these posts are, so to speak, on the immediate scene of action, the ambulance would not generally be called upon to serve the posts. Most of the in-coming patients would go to the first aid posts without help, or would be taken in by stretcher teams. After receiving treatment, some would have to be taken on to casualty stations and hospitals by ambulance.

The duties of the chief of the Emergency Medical

Service during the period of preparation fall into five general classifications, namely; organization of the field casualty service with field units named from each hospital in the community; hospitalization of casualties; medical direction at the control center; collaboration with the Red Cross; and the organization of casualty information and mortuary services. During the period of operations, he or one of his deputies must serve as medical adjutant at the control center.

The medical adjutant must have complete knowledge of the number and availability of all field service units at his disposal. He must know the number and location of vacant hospital beds in the city. He must provide for emergency hospitals when these are filled and the maximum daily operating load each hospital can assume. On report of casualties, he will order the dispatch of medical field units under the general supervision of the commander or controller. Although a civilian, the medical adjutant must move with military efficiency.

We hope that the disasters of war never come to Kansas but we must be prepared to meet any emergency. Our present first aid and hospital facilities are inadequate to meet such needs. Just as police or fire department service might be inadequate. It is absolutely imperative to have voluntary workers well-trained, to supplement the help of professional people.

A great many persons turn to the corner drug store for medical supplies in cases of minor accident or illness. Here in Kansas, the State Pharmaceutical Association has established a plan through which the "corner drug stores" become an information center. The plan is not to make the drug store a casualty station but that in the event of an emergency—you may quickly determine the location of the nearest casualty station by inquiring at the store.

The Association has worked out an excellent plan with two captains for each county, and these individuals have the responsibility of seeing to it that medicinal, surgical, and first aid supplies are on hand.

Ambulance service in Kansas will be made available in case of wide spread need as follows: the Funeral Directors and Embalmers Association of Kansas recently submitted to the State Council a plan of assistance which was gratefully accepted. Under this plan, virtually every ambulance in Kansas has been catalogued so that it may be called upon for instant service when needed. Along with the ambulances, the funeral directors are furnishing crews of first aid workers and a certain amount of first aid equipment.

The ambulance service is broken down into county units, each working directly with its local council. In this way, emergencies in local communities may

be handled quickly and effectively. In addition, we know where almost every ambulance in Kansas is located, and can summon hundreds to one central point, anywhere in the State, in the event of a major disaster.

The Kansas Funeral Directors and Embalmers Association has organized a corps of 681 ambulances, under the direction of State Senator Ernest McKenzie of Cottonwood Falls, Chairman of the corps. The Association also provides 369 attendants and certain supplies. Although this represents about ninety-five per cent of the available equipment in Kansas, it might be insufficient. In the case there would be a shortage of ambulances, and that other forms of transportation might be required, automobiles could be used instead of ambulances. Light delivery trucks, in some cases could serve as well. Incidentally, the Kansas Embalmers Association has made provisional arrangements for using such trucks in connection with the morgues which would have to be established in the event of a major disaster.

Kansas seems fairly well prepared for the emergency we all hope will never arrive. The State Council of Defense, our local councils, the Emergency Medical Service, the corner drug store, and all other agencies concerned can and would be of great assistance in saving lives and easing pain if an emergency should occur. But they cannot do it all, when the need comes it may be over-whelming. Each individual and each family should prepare in every practical way. If you are studying first aid, or enrolled in a nurse's aid, or home nursing courses, don't think of it as a civilian defense task which you are carrying out simply because you have a vague idea of doing something patriotic. Remember the knowledge you gain may some day save your own life, the life of a loved one, or the life of a neighbor. In time of great need there occurs human understanding and sympathy that levels all social barriers—you help the other fellow and the other fellow helps you.

Never before in our history have we needed such safe, sane leadership as in the next few years to come, and we should be considering that very thing most carefully right now. Each of our county medical societies, the "grass roots" of organized medicine, should see to it that their officers to come will be men of more than ordinary ability, men of vision if you please.

For some years past we have heard the expression "Medicine at the Crossroads"; we believe that just now, medicine has definitely arrived at that point and the vital question is "Which way shall we take?"—Journal of The Indiana State Medical Association.

THE KENNY TREATMENT

WITH A NOTE ON ITS USE IN KANSAS
TWENTY YEARS AGO

Karl A. Menninger, M.D.

Topeka, Kansas

The great success of the "new" Kenny treatment for poliomyelitis has recalled to my mind an episode in Kansas medical history which may be worth recording. The techniques of the Kenny treatment were used in Kansas nearly twenty years ago and reported in this Journal!

In March, 1940, Sister Elizabeth Kenny of Australia came to this country to demonstrate a technical procedure in the physical treatment of poliomyelitis which has come to be known as the Kenny treatment. Although she had letters of introduction to the president of the National Foundation for Infantile Paralysis, the American Medical Association and the Mayo Clinic, she met with continued rebuff and discouragement. More accurately stated, she was sent from one man to another, round and round, on and on. None of the earlier interviewers were much impressed by her claims.*

Since then she has so completely convinced leading orthopedists that Dr. Frank Ober, head of the orthopedic department of Harvard Medical School, and Dr. Irvine McQuarrie, professor of pediatrics at the University of Minnesota, among others, have said such things as this: "If one of my children had poliomyelitis, I would want to have the Kenny method of treatment used."***

Dr. Philip Lewin of Chicago, chairman of a medical committee of the National Foundation for Treatment of Infantile Paralysis, who had vigorously opposed the procedure at first, has put in writing that "the Kenny treatment is one of the most outstanding advances in orthopedic surgery (sic!) since the time of Hugh Owen Thomas and Sir Robert Jones."***

The essential details of the treatment have been reported in many articles available to the profession. It depends upon the recognition of three major symptoms previously understressed in the clinical descriptions of the disease. The first of these is the muscular spasm; the second is the incoordination

*Note—Dr. Miland Knapp, head of the department of Physical Therapy of the University of Minnesota, and Dr. F. H. Krusen, of The Mayo Clinic, finally gave her the opportunity to demonstrate what she could do.

**See Observations on the Kenny Treatment of Poliomyelitis, by F. H. Krusen, M.D. Proceedings of Staff Meetings of The Mayo Clinic, 17:449-460, August 12, 1942.

***Illinois Medical Journal, 81:281-296, April, 1942.

which may be of two types—"(1) that due to the spreading of motor impulses intended for a certain muscle to other muscles or groups of muscles due to such conditions as pain on attempted motion of the involved muscle or inability of that muscle to perform its proper function, (2) that occurring within the involved muscle itself, so that ineffective contraction is produced instead of a coordinate rhythmic contraction producing maximum motion at the insertion of the muscle." The third symptom is the disturbance in central nervous control, "the inability to produce a voluntary purposeful movement in a muscle" despite intact nerve paths. This is a physiological block rather than an organic interruption.

The treatment based upon this conception is: (A) placement of the patient in a basic position in bed on a firm mattress with bed boards beneath the mattress and a footboard propped away from the end of the mattress by wooden blocks; (B) the application of hot packs made of old woolen blankets cut into proper shapes, wrung out of boiling water and applied along the muscles but not over the joints. They are covered by a layer of oiled silk and another layer of dry blanket. They are removed frequently, from fifteen minutes to two hours, and continued uninterruptedly. (C) Passive motion to the extent possible without producing pain. (D) When spasm decreases the introduction of active movement. (E) When all the spasm is gone, re-education of muscles.

In a recent description of the treatment, read at the Golden Belt Medical Society meeting and published in the *Proceedings of the Staff Meetings of the Mayo Clinic* (op. cit. supra), Dr. Frank Krusen concludes with these significant paragraphs:

"I have tried to describe, from a detached viewpoint, the amazing phenomenon of the remarkable interest in the Kenny procedure. I am now, for the first time after more than two years of observation, expressing a favorable reaction concerning it. Time alone will permit sane consideration of the value of the method, but certainly it offers promise of being a most valuable procedure. My first impression of Miss Kenny was not too favorable and I was rather taken aback by her belligerent attitude; and as I told her recently, I was sure that she was a little unbalanced when she spoke of overcoming toedrop in a day or so. But since I have come to know her better, I have learned to admire her, to understand her belligerence, and to applaud her courage. Her ideas are original, and she should be given full credit for having developed a new and extremely interesting concept of the symptoms of early poliomyelitis and the proper management of these symptoms. The Kenny method merits the close scrutiny of every physician."

In 1923, nearly twenty years ago, there was an epidemic of poliomyelitis in Kansas, corresponding to similar epidemics in many parts of the country. At that time poliomyelitis was the disputed territory of the pediatrician, the neurologist and the orthopedist. The neurologists were perhaps a little in the lead—prior to 1923. Under their direction, the treatment of partial paralysis was based chiefly on re-education. Some orthopedists, on the other hand, ignoring the influence of cerebral centers, ignoring the patient's psychology and often ignoring the question of pain, put their chief reliance upon immobilization. The author remembers several sharp altercations with orthopedists and others who immediately encased paralyzed limbs in plaster casts. It has now been demonstrated that with the Kenny treatment paralyzes and deformities do not occur to anything like the same extent as with this immobilization treatment.

In the *Journal of The Kansas Medical Society* for October, 1923, (pages 278 ff), in conjunction with articles by my father and my brother Will, I outlined a treatment for poliomyelitis which included (along with serum and other medical treatment) an outline for the treatment of the convalescent stage by "protection, muscle training, thermal therapy, and massage."***** The application of hot packs wrapped in woolen cloths wrung out of boiling hot water, covered with oiled silk and more wool, exactly as prescribed by Miss Kenny, is recorded. We treated numerous patients by this method, and I am happy to say that twenty years later not one of them, to my knowledge, is unable to walk and some of them are completely free from any residual symptoms whatsoever.

The chief credit belongs not to me but to a Swedish masseuse and physiotherapist who was associated with the Menninger Clinic at that time, Ingeborg Lindquist, now Mrs. Swanson, who was trained in the Royal Institute for Physiotherapy of Stockholm, Sweden. She brought this training to America, modifying her procedure somewhat in the light of the muscle training exercises developed by Frenkel of Germany and Miss Wright¹¹ of Boston, at my suggestion. She came to Topeka and affiliated herself with us in 1921 and applied this treatment under our direction to our patients in Christ's Hospital.

Poliomyelitis has long since ceased to be any considerable part of the work of the neurologist or the psychiatrist but it is gratifying to know that neuro-

***** The Cerebrospinal Fluid in Acute Anterior Poliomyelitis—William C. Menninger, M.D., Topeka. Jr. Kans. Med. Soc. Sept. 1923. Symptomatology and Diagnosis of Acute Poliomyelitis—C. F. Menninger, M.D., Topeka. Jr. Kans. Med. Soc. Oct. 1923. The Treatment of Poliomyelitis—Karl A. Menninger, M.D., Topeka. Jr. Kans. Med. Soc. Oct. 1923.

logic and psychiatric principles, introduced to the author by a physiotherapist from Sweden and now re-introduced to this country by a nurse from Australia, have been taken over by the orthopedists and pediatricians of America to the great advantage of sufferers from poliomyelitis.

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Approximately five thousand physicians are graduated in the United States each year, and it is estimated that during the next three years this figure will be materially increased due to the step-up in medical education—the continuous school plan. This figure is estimated to reach 21,000 graduates. Each of these graduates, however, will be taken into the armed services immediately on completion of their interne year, practically none of them being released for civilian practice until the conclusion of the war. This will, of course, lighten the load to a very great extent, making it necessary for fewer established practitioners to enter the service. It is further estimated that by the end of the three-year period mentioned, practically every physically fit physician under the age of fifty-five will have been called into service. So, it is quite clear that our medical distribution problem will ever remain before us.—*Journal of The Indiana State Medical Association.*

Sixty thousand Americans, most of them young, die each year of tuberculosis. Compared with the loss of life from this cause a century ago, it is a triumph that there are only 60,000. Compared with the number who could be saved by the prompt application of modern knowledge, it shows gross neglect that there are so many.—*Surgeon General Thomas Parran, Survey-Graphic.*

INTRAVENOUS FLUIDS

J. L. Lattimore, M.D.

Topeka, Kansas

In recent years a vast amount of material has appeared in the literature about various intravenous fluids, yet in spite of this, there appears to be a lack of understanding as to the fluid that is indicated, whether it be blood, blood plasma, salt solution or glucose. Yet with certain laboratory determinations, we can make the proper choice in a given case.

The first recorded transfusion was given in 1490 and Pope Innocent the VIII was the recipient. Almost every generation of physicians has worked on blood transfusion, but each met the same obstacles, infections, hemolysis, coagulation and agglutination. Not until Landsteiner's work in 1900, which classified three blood groups, was the matter of hemolysis and agglutination explained. Then, in 1907, Jansky described the four blood groups; and three years later, Moss carried on similar experimental work and obtained the same results, but unfortunately, he transposed the groups of Jansky, leaving much confusion about groups one and four. In 1921 a committee from the American Medical Association recommended the use of Jansky's classification. Then later, the matter was better clarified when the International classification was adopted by most scientific groups, so now the terms, O, A, B and AB are in almost universal use.

In 1927, Landsteiner and Levine discovered three agglutinins and named them M, N and P. They studied at length M and N and developed satisfactory methods for identifying them. They are of such nature that they very seldom play any part in transfusion reactions but are of aid in some medico-legal cases, in determining parentage.

Recently, there have appeared several articles about the Rh factor. About eighty-five per cent of all people belong to the Rh positive group and about fifteen per cent to the Rh negative group. Many abortions, macerated foetuses, toxemias, still births and erythroblastosis foetalis have been reported in which the wife was Rh negative and the husband Rh positive. Recently, I observed a family of a husband and wife, in which the wife had aborted six times, within the first five months of pregnancy. Upon examination of their bloods, we found the wife Rh negative and the husband Rh positive. Transfusion reactions, some resulting in death due to hemolysis, have been reported when Rh positive blood is transfused to Rh negative individuals. The first transfusion of such blood does not cause serious

reactions but immediately the Rh negative individual develops immune iso-antibodies against the Rh positive blood, so that a second transfusion, using Rh positive blood causes a severe reaction and has resulted in some deaths. To date, the reactions reported, so far as I know, have occurred in post-partum cases, there being an antigenic factor in the embryo, that develops or aids in developing the iso-antibodies. One report states that the storage of blood or plasma in the ice box decreases the Rh factor.

It is not within the scope of this paper to discuss the indications for body fluid in shock. Assuming that the patient needs fluid, I would like to present a procedure for the determination of the best fluid to use. There is no laboratory procedure to definitely determine dehydration, this must come from a clinical examination of the patient. However, when the physician has determined that the patient is dehydrated there are several laboratory tests, that will help him to determine which fluid is indicated.

In shock the ideal fluid is whole blood. It is seldom that whole blood is available within a few minutes, therefore, routinely plasma is used immediately and then donors are secured for transfusion. Plasma may be used either in the dehydrated or in liquid form. The dehydrated form need only have water or salt solution added and the administration can be started in a very few minutes.

Previously prepared liquid plasma can be used immediately. Every hospital, regardless of its size should have its own small plasma bank. The total cost for setting up a suitable collecting system is only a few dollars and requires the supervision of a physician to collect the blood and a laboratory technician to separate the blood and to check sterility. Blood typing is not necessary in plasma, although there have been some reports apparently aiming at blood plasma containing an excessive amount of agglutinin.

When the administration of fluid is not such an emergency, the physician can take ample time to perform certain tests. The hematocrit determination shows the relationship between cells and serum of the patient. The technic is very simple and can be done in a few minutes. The normal hematocrit reading for males is forty-two to fifty per cent and for females is thirty-nine to forty-three per cent. It is obvious if you had a hematocrit determination of sixty per cent that the addition of more cells merely makes more of a cellular imbalance. To a certain extent the erythrocyte count tells the same story, since a patient with a normal red count should not receive a whole blood transfusion, unless for some reason other than dehydration or cell replacement.

The next step should be the blood protein determination, which can be made, either by chemical test or by taking the specific gravity of the blood and then converting this figure into protein. The chemical test for protein requires considerable skill, while the specific gravity is simple. However, in my hands, the specific gravity for males is 1.0566 and for females 1.0535. This converted into protein gives normal reading of 5.9 to 7.9 per cent, the average being 7.0 per cent. In cases showing a low protein either whole blood or plasma is indicated. Thus by these two tests we can determine whether whole blood or plasma is indicated.

It is not uncommon to see a patient virtually drowned in salt solution when administration follows no definite idea of the factors involved. More often this is a result of a low protein and the addition of more saline merely increases edema and circulatory embarrassment. There are also a number of clinical conditions that contraindicate the use of salt solution. The normal chloride in the blood is 450-550 mgm. and it is wise to make a chloride determination before the administration of much salt solution. Fortunately, the more common condition is a low chloride.

If the hematocrit determination is normal, the protein normal and the chloride normal, then glucose should be used, providing of course that the patient is not a diabetic. The normal blood sugar is eighty to 100 per cent and all blood sugar determinations should be made on a fasting patient.

I have made some effort to determine, from hospital records, the frequency of transfusion reactions but am unable to form a clear idea, as some physicians consider a slight rise in temperature as being a transfusion reaction while others require an actual chill. You can see that statistics on transfusion reactions are not very accurate, however, a figure of five to seven per cent is approximately correct for reactions. Most of the severe reactions are hemolytic in nature, associated with hematuria, passing of blood from the intestines and mucous membranes. The delayed reactions are almost invariably due to failure to cleanse equipment properly.

One can find reports of associated hypoproteinemia with almost every condition; however, the most common diseases associated with a low protein are peptic ulcer, ulcerative colitis, biliary fistula, intestinal obstruction, ileus, appendicitis, chronic suppurative diseases, vomiting, diarrhea, burns, profuse drainage from an abscess, nephrosis, glomerular nephritis, cirrhosis, toxemias of pregnancy and fluid administration.

Fowler and Barer of Iowa City found that the

(Continued on Page 423)

President's Page

TO THE MEMBERS OF THE KANSAS MEDICAL SOCIETY:

Our new Executive Secretary, Mr. Robert (Bob) Brooks, has assumed his duties in our central office as of October 1. The Executive Secretary Committee had a number of very fine applicants and we believe that a very excellent choice has been made. I know Robert Brooks will have the help and advice and the heartiest cooperation of our entire membership in his new work.

Each member has recently received a notice on the use of cars and tires by physicians. There have undoubtedly been some violations of our privileges in the use of cars and tires in this national emergency. For the most part, these have occurred either from thoughtlessness or lack of knowledge of what the limitation should be in their use. I have assured the State Rationing officer that the medical profession for patriotic reasons alone wishes to cooperate completely in limiting the use of cars and tires to permissible and necessary driving. Much discredit will come to the medical profession if any of us give cause for complaint. I am sure that our profession will carefully and cheerfully observe these regulations made in the interest of our country's welfare.

This month brings to the foreground interest in the November election. We have many members in each of the two major political parties who will work for the welfare of their party candidates. It is the duty of each member to take an active interest in the election.

Sincerely,

Henry N. Tichen, M. D.

President, The Kansas Medical Society.

EDITORIAL

NEW EXECUTIVE SECRETARY

The Journal welcomes Mr. Robert Brooks, the new Executive Secretary of The Kansas Medical Society, to the Society central office and introduces him to the Journal readers, the members in the state organization and the hundreds of members in the military services. We all wish him the best of success in his new undertaking.

Mr. Brooks, formerly Secretary of the Winfield Chamber of Commerce, was chosen from the eight splendid applicants who were interviewed to fill the position left vacant by the resignation of Clarence Munns, who was recently commissioned as a Lieutenant in the Air Force. The Council granted Mr. Munns a leave and as a result it was necessary to secure a new Society Executive Secretary.

Dr. Henry N. Tihen, President, was empowered by the Council at its August meeting to appoint an executive secretary committee, which would receive applications and later interview applicants. The following members were appointed to serve on the committee: Dr. Warren Bernstorff of Winfield, Dr. W. P. Callahan of Wichita, Dr. F. R. Croson of Clay Center, Dr. J. L. Lattimore of Topeka, Dr. W. M. Mills of Topeka, Dr. C. C. Nesselrode of Kansas City, and Dr. Marion Trueheart of Sterling. Dr. Tihen of Wichita acted as Chairman. At a meeting of the committee held on September 13, Mr. Brooks was selected as the new Society Executive Secretary.

Robert Brooks was born in University Place, Nebraska. He attended the Peabody and Kingman grade schools, Pratt High School, and was graduated from Southwestern College of Winfield. He later attended the University of Pennsylvania of Phila-

delphia and the University of Kansas. He is married and the father of three children.

After completion of his school work he was first employed as an instructor in high school, was later and auditor for the Farm Credit Administration at Wichita and employed by the Wichita Chamber of Commerce.

The position of Executive Secretary to The Kansas Medical Society was created in 1934, at which time Clarence Munns was selected for the newly created place. It is believed that Mr. Brooks will most ably and adequately fill the position so energetically, capably and devotedly held by Clarence Munns since its inception.



1943 A. M. A. MEETING CANCELLED

According to word received in the office from Dr. Olin West, Secretary of the American Medical Association, the 1943 annual meeting of that organization has been cancelled.

Dr. West in a letter to the Editor says. "After prolonged and intensive consideration, the Board of Trustees of the American Medical Association has come to the conclusion that the annual session of the Association scheduled to be held in San Francisco in 1943 should be cancelled. An official announcement to that effect will appear in the Journal of the American Medical Association. This decision of the Board of Trustees was made after securing the best available official information and after thorough consideration of the many factors involved."

"An official meeting of the House of Delegates of the American Medical Association will be held in Chicago at a time to be announced."

With transportation facilities congested, gasoline and tires rationed and the war demands on civilians and physicians alike up to a peak of activities, it is indeed a wise decision and one that no doubt, was reached after long and momentous deliberation. This

decision, will no doubt also affect many state meetings in a like manner. It has already been noted that cancellation has been made of several state meetings throughout the central and mid-western states. All of the official business of the organizations will undoubtedly be conducted in as brief a time as possible, since the war has made it imperative to dismiss as incidental or trivial much of the usual scientific work conducted and subordinate everything to the war effort.

NEW SERIES FOR JOURNAL

The Editorial Board is happy to announce that with the October issue it is attempting to give a new idea to its readers. The Board has prevailed upon Dr. William C. Menninger of the Menninger Clinic of Topeka to write a series of articles for publication in the Journal from time to time, on the fundamentals of psychiatry.

It is believed that Dr. Menninger will take up the following subjects in this regard: The Interrelationships between Medicine and Psychiatry, the History of Psychiatry, Mental Hygiene, Classification of Mental Illnesses, General Treatment in Mental Disorders and a number of other interesting phases of the subject.

The Board is of the belief that the new innovation will be of great interest to the medical profession.

THE KENNY TREATMENT

It is interesting to note that a treatment, similar in procedure to the much publicized Kenny infantile paralysis treatment, was used in the city of Topeka during the poliomyelitis epidemic of 1923.

Dr. Karl A. Menninger, of the Menninger Clinic of Topeka, discusses the treatment used at that time and the general results obtained in an article in this issue of the Journal. We believe that it will be of great interest to our readers. In 1923 the Journal published three articles on the subject in the September and October issues written by Dr. William C. Menninger, Dr. C. F. Menninger and Dr. Karl Menninger.

At the time of the publication of the above articles an epidemic of poliomyelitis had swept Topeka, with thirty-six cases reported in a period of fifty-seven days by the State Board of Health. The victims were from twenty months of age to thirty years.

The treatment, as described in Dr. Karl Menninger's article, coincides closely with that used in the Kenny treatment, now accepted by the National Foundation for Infantile Paralysis, whose

financial grants at the Medical School of the University of Minnesota, under the direction of the Department of Orthopedic Surgery and Physical Therapy, are implementing the further study of the methods used.

THE HOME FRONT

Serious indeed are the situations in many communities of the state with respect to medical service and nursing, with the approach of winter. While many medical men and women realize the potential dangers, the public seems not yet to be fully aware of them.

Industrial accidents and illness are receiving increasing attention, and machinery for their prevention and care is being set in motion at an accelerated pace by national, state, and county medical societies, health departments, nursing associations, industry itself. But recent news reports seem to indicate that there will undoubtedly be difficulties in maintaining adequate heating in many private homes and other buildings; hot water supplies will probably be rationed. Conversion of oil heaters to coal or gas may not always be possible. Increases in respiratory infections, in industrial accidents, and illness are to be expected. In many localities, hospital facilities, both as to beds and to nursing and medical attention, will be insufficient to cope with increased demands upon them when these arise. Meatless days are already on the horizon; gasless, doctorless, and nurseless days and nights are not far off.

However, nothing is ever quite so bad or so good as it seems. The nation now has a vast reservoir of people trained in first aid—thanks to the tireless effort of the American Red Cross and the many physicians and lay instructors who have taught them. Nurses' aides are becoming more plentiful, enabling the hospitals to carry on in spite of the depletion of registered nurses. But not all of the women who might become nurses' aides can do so because of home, economic, or other factors.

Home nursing, however, can be of inestimable value in view of the fact that many families will of necessity have to rely on their own resources this winter, and, in addition, may have to care for a neighbor. Instruction in home nursing could be a practical attack on the problem of the maintenance of community health. It could be made a required subject in the public schools; it could be made a continuation course for many of those who have finished their first aid instruction. Everybody can help. Physicians should bring home to their patients and their families the necessity for such training. Retired nurses or those not on active duty must

provide the instruction and will do so.¹ The insurance companies doubtless can and will assist in bringing home to their insured by advertisement and contact the necessity for adequate training in home nursing.

The problem is primarily one of educating the public to the necessity for this kind of training. There is no reason to think that, once the necessity for it is understood, there will be any lack of capable response. This is something that each community can do for itself with the help of the Red Cross and the nurses.

We are obtaining nurses' aides in ever increasing numbers. Why not doctors' aides?—New York State Journal of Medicine.

1. The American Journal of Nursing for July, 1942, page 770, lists inactive nurses in New York State at 3,262, of whom 279 are available for institutional work; forty-five for public health; 1,060 for private duty; eighteen for industrial nursing; and 538 for other duty.

MALARIA AND QUININE POLICY OF GOVERNMENT

India started cinchona cultivation as far back as 1860. Dr. Forbes Royle, the then Superintendent of the Botanical Garden, Shaharanpur, offered the suggestion for such plantation and selected the Nilgiri Hills in South India and the Khasia Hills in Assam as suitable sites. But it was not until 1860 that an experiment for growing cinchona in this country was undertaken at the instance of Mr. Clement Markham.¹ We find from the official reports that in 1880 about 10,000 acres of land in various places in India such as Mungpoo, Darjeeling, Nilgiris, Wynad and other places were utilised for this purpose and the dry barks obtained amounted to 950,000 lbs. In Ceylon, on an area of 33,500 acres, 1,000,000 lbs. of the bark were obtained in that year, whereas Java produced only 450,000 lbs. The original red bark was not suitable for manufacture of quinine sulphate, but gradually the quinine producing family of *Calisya* was obtained in sufficient quantities. The present product of cinchona grown and known as *Cinchona Ledgeria* contains on an average five per cent of quinine alkaloid and an acre of land yields about 2,300 pounds of bark yielding about 115 lbs. of quinine sulphate.

The number of sufferers from malaria in India ranges from 100 to 200 million. According to Col. Russel, India requires, on the basis of disbursement of forty-five grains to each patient, 600,000 lbs. of quinine only every year. The official report of 1939, however, states "In reality, however, India needs

about 210,000 lbs. of quinine of which approximately a third or 70,000 lbs. is produced in India, leaving 140,000 lbs. to be supplied by importation." The whole of the 140,000 lbs. used to be imported from Java and this supply was controlled by this Dutch combine, Kina Bureau. On the other hand, after careful analysis of soil, rainfall, etc., it has been found that 38,000 acres of land are available in this country for cinchona cultivation and this could produce 6,840,000 lbs. of quinine—100 times the amount she is producing now or ten times the amount India actually needs.² So we see that India contains more than sufficient land suited to conditions of cinchona cultivation and the Royal Commission of Agriculture (1928) strongly recommended for the extension of the present area under cinchona cultivation so as to make us self-sufficient in the matter of quinine supply.

The Indian Medical Association had been repeatedly trying to draw the attention of the Government to this deplorable state of affairs since 1931.^{3,4} The demand for quinine self-sufficiency was reiterated almost every year in the annual conference and resolutions were passed unanimously.⁵ Our advice fell on irresponsible ears. The "Quinine ring" still reigned in close collaboration with the Anglo-Dutch plantation Company and maintained a price as high as Rs. eighteen (prewar) per pound although the cost of production was Rs. nine per pound.⁶ In 1941-1942 the Mungpoo plantation showed a profit of about nine lacs of rupees.⁷ It is nothing short of tragic that sheer profiteering should prevail in a commodity which is essential for India's health and happiness.

Major General Sir Charles Macwatt, late Director General of the Indian Medical Service observed.⁸ "If we were involved in another war we would endeavor to produce the munitions to wage it within the Empire, as far as possible. In this chronic and intensive warfare against the deadly foe—malaria—India can supply only four per cent of its munitions to combat it, in the shape of alkaloids of the cinchona bark. We are obliged to go outside the realms of the Empire to get what is required and that at a cost which the vendors can dictate and fix. In India

2. Krishnan quoted by K. S. Ray—J. I. M. A. 10. 194. 1941.

3. J. I. M. A. (then the Indian Medical World) I. 465. 1931.

4. Ray, K. S.—J. I. M. A., 10. 194. 1941.

5. J. I. M. A. 10. 202. 1941.

6. Elizabeth, Duchess of Carnarvon—Malaria, course, cause and cure. p. 30.

7. Explanatory Memorandum on the Budget of the Government of Bengal 1942-1943—pp. 41, 105.

8. J. I. M. A. (then the Indian Medical World) I. 473. 1931.

1. J. I. M. A. (then the Indian Medical World) I. 464. 1931

the demand for some years has been for swadeshi products. Cinchona plantations are very laudable swadeshi products giving occupations to the citizen of the soil of Mother India and keeping money in the country." He seems to be a true prophet regarding the war only. With the fall of Java, the importation of quinine has stopped. The position is serious with the approach of the malarial season. Already there has been a dearth of quinine in the market. With the prewar available quinine the mortality rose up to million figure and we cannot imagine the horrible and tragic fate of sufferers without the two thirds supply of quinine. This becomes more evident when we remember that malaria is both preventable and curable.

Cinchona plant cannot be grown overnight. Valuable time has been lost since the recommendation of the Royal Commission of Agriculture. Inefficiency, complacency, red tapism and lack of sympathy towards the suffering Indian population are causes of this tragedy which we all have to face in near future.—Journal of India Medical Association, Calcutta, India.

TUBERCULOSIS CONTROL

PULMONARY TUBERCULOSIS AMONG SPANISH-SPEAK- ING PEOPLE

It is a well established fact that the incidence of pulmonary tuberculosis varies markedly in different races. Roughly, there appears to be an increase in incidence as the pigmentation of the skin characteristic of the race increases, and also increasing with the magnitude of climate change occurring when the darker skinned races migrate to colder regions. Thus, a native of the tropics coming to Colorado to live is more liable to contract tuberculosis than is a native Coloradoan. Whereas the present death rate for tuberculosis in the United States Registration area is approximately thirty-six (in 1940) per 100,000 population in whites, the rate for Negroes is almost three and one-half times that number.

The incidence of tuberculosis in the Mexican falls between the rates for Negroes and whites. However, reported figures have shown fairly wide variations. These variations are to be expected, inasmuch as the Mexica who was born and raised in the Rio Grande valley and who later moves across the river into the Texas side of the valley has made no change in climate at all, but the Mexican who migrates from

Monterey to Colorado has made a very decided change. It is therefore expected that the incidence of tuberculosis among Mexicans coming to Colorado will be greater than that among those stopping in southern Texas, New Mexico and Arizona.

The Weld County study, under the joint sponsorship of the Weld County Tuberculosis and Health Association and the Weld County Health Department and Public Health Laboratories, shows the tuberculosis problem which exists among the several thousand Mexicans residing in this Colorado county. Nearly all of them are occupied in farm work, mainly the planting and harvesting of sugar beets. Over half of them live in "Spanish Colonies." Living conditions are quite uniformly sub-standard and crowded. This undoubtedly contributes in no small measure to the picture presented by this study.

During the thirty-month period September 1, 1939, to March 1, 1942, a case-finding program was carefully conducted among the Mexican population of Weld County. A total of 1,745 persons were tuberculin tested and all positive reactions followed up with an x-ray. Of the reported such studies, very few have contained complete follow-ups of all positive reactors. The Weld County study is now complete except for the progress following diagnosis and treatment of all active cases found.

The tests were made, for the most part, in "Spanish Colonies" after showing a series of educational films produced by the National Tuberculosis Association. The interest response was very gratifying and all age groups attended, as is shown in the figures of Table I. The ages ranged from less than two years to over seventy.

The remainder of the persons included in the study were segregated from the testing programs carried on in the schools of the county, and a few persons who were tested for various reasons. On the whole, the group studied should represent a nearly accurate cross section of the Mexican population of the county.

The results of the study are diagrammatically shown in Table I. Of the 1,745 tuberculin tested, 745, or 42.7 per cent had positive reactions. These 745, along with forty other persons from families in which active tuberculosis was found, were given chest x-rays. These forty people had not had previous tests.

TABLE I

Total Tuberculin Tests.....	1,745
Under sixteen years.....	986
Over sixteen years.....	759
Negative Reactions	1,000
Under sixteen years	702
Over sixteen years.....	298
Positive Reactions	745

Under sixteen years	284
Over sixteen years	461
All 745 reactors given chest x-rays	
Known Contacts	40
Forty members of families with active tuberculosis also x-ray; total of 785 chest x-rays	
Chest Films with Negative Findings.....	481
Referred to Chest Clinic for further study	304
Active Tuberculosis Cases Discovered.....	61
Sanatorium recommended	47 cases
Pneumothorax clinic and home care	3 cases
Hospitalized by Las Animas County	1 case
Died in Island Grove Hospital pending sanatorium care.....	10 cases
Admitted to sanatorium.....	42 cases
Refused sanatorium treatment....	2 cases
Left the county.....	2 cases

In 481 of the chest x-rays, there was no evidence of tuberculous activity and they were dismissed from further study.

In 304 cases radiographic evidence ranged from merely suggestive to definite evidence of pathology. These were referred to the Chest Clinic of the County Health Department for further study, including physical examination, sputum examinations and cultures. Sixty-one were found to have active pulmonary tuberculosis. The disease status of the active cases is shown in Table II.

TABLE II

Disease Status of the Sixty-one Active Cases	
Far Advanced	51
Recommended to sanatorium care	41
Died in Island Grove Hospital.....	10
Moderately Advanced	4
Recommended to sanatorium care.....	1
Pneumothorax and home care.....	3
Minimal	4
Followed in Chest Clinic	
Refused to cooperate so that evaluation of their disease status is impossible, probably moderately advanced	2

SUMMARY AND CONCLUSION

Of 1,745 tuberculin tests given, 745 positive reactions, or 42.7 per cent, were found. These were given chest x-rays, as were also forty others from families in which active tuberculosis was found. Of the grand total of 1,785 cases, 304, or seventeen per cent, were at least suggestive of tuberculous pathology, as shown on the x-rays. Further study revealed sixty-one cases, or 3.42 per cent, active tuberculosis.

Based on this study, the incidence of tuberculosis among the Mexican population of Weld County is found to be the staggering total of 34.17 per 1,000 population.—From Tuberculosis Abstracts, October, 1942. Pulmonary Tuberculosis Among the Mexican Population of Weld County, Colorado, William J. Wilson, M.D., Rocky Mountain Medical Journal, June, 1942.

INTRAVENOUS FLUIDS

(Continued from Page 416)

average young male donor of 555 cc. of blood had a hemoglobin drop of 2.5 grams (sixteen per cent) and that it required forty-nine days for this loss to be replaced.

Errors in typing are usually due to the fact that the technician uses typing sera of too low titre. Insist that all typing sera be of known and accepted agglutinin content and that it be pooled from several donors.

It must be born in mind that courts have held that it is malpractice for a physician to transmit syphilis by transfusion, unless he has had a serological test done on the donor and that test is negative. Even with all precautions, there are instances of syphilis being transmitted by transfusion. It is well known that some patients may harbor spirocheta in their blood, especially early in syphilis, yet not show enough reagin to give a positive serological test. No doubt some of the trouble has been the failure of the technician to read positive flocculation tests. One well known serologist has stated that no technician should be permitted to attempt to read or interpret a flocculation test until she has done at least 3,000 tests.

By adopting systematic routine, the physician can accurately determine if the patient should receive whole blood, plasma, chlorides or glucose intravenously.

NEWS NOTES

SECRETARIES AND EDITORS CONFERENCE

The Annual Conference of Secretaries of Constituent State Medical Associations will be held in Chicago on November 20-21. With the cancellation of the American Medical Association 1943 meeting, such meetings will of necessity be of great importance to the organizations personnel who attend the conference.

This year's conference will in the main be made up of the war problems affecting the state organizations and the difficulties that may develop as a result of the intensifica-

tion of the war needs. The conference is attended by editors, secretaries and other officers of the state associations.

HOSPITAL PERSONNEL AT BOMBER BASE

The station hospital at the Topeka Air Base has brought a welcome addition to the medical ranks in Topeka. These Army medical officers are entering into the medical life of the city and are caring for the families of enlisted men and have voluntarily made examinations of school children, thereby relieving the local physician shortage.

The officers have come from many states and it is believed that the membership might be interested in a list of the personnel. Major Herbert C. Merillat, formerly of Indiana and Washington is the surgeon in charge of the hospital. Others located at the base are as follows: Major John V. Fopiano of Michigan, Captain Clarence V. Rozell of Indiana, Captain William T. Ale of Michigan, Captain Donald Reed of Indiana, Captain George L. Thorpe of Kansas, Captain Martin Ryan of Iowa, Captain Clarence Schmidt of Kansas, Lieutenant Gilbert C. Lapid of Indiana, Lieutenant Henry Spitzer of Michigan, Lieutenant Everett M. Steffes of Michigan, Lieutenant Karl E. Seidel of Michigan, Lieutenant Meredith Berry of New York, Lieutenant Victor E. Linden of Michigan, Lieutenant Arthur Weihe of Illinois, and Lieutenant Lawrence Solberg of California.

NEW COMMITTEE CHAIRMEN

Dr. Henry N. Tihen, President, recently announced the appointments of the following new committee chairmen: Dr. George Paine of Hutchinson to succeed Dr. Robert Klein of Dodge City as Chairman of the Committee on Public Health and Education; Dr. E. N. Robertson of Concordia to succeed Dr. George Gsell of Wichita as Chairman of the Committee on Conservation of Eye Sight; and Dr. J. S. Reifsnider of Wichita, to succeed Dr. Lyle Powell of Lawrence as Chairman of the Committee on Conservation of Hearing.

Dr. Klein, Dr. Gsell, and Dr. Powell recently resigned their positions as chairmen of the above mentioned committees to enter military service.

NEW A. M. A. DIRECTORY

The new Seventeenth Edition of the American Medical Directory has arrived in the office. The new directory is a splendid contribution to the war effort and is of great value to offices and others releasing information on the profession.

The new directory covers not only the United States but also Canada, Alaska, the Canal Zone, Hawaii, the Philippines and Puerto Rico. In as far as is possible, due to an early closing date, the directory contains data on physicians who had at that time already joined the armed forces. Doctors of medicine who are now officers in the Reserves, in active service, and in the National Guards or on active duty are listed at their permanent home address with symbols designating the Army, Navy, or the Guard service. Medical officers in the regular United States Army, Navy and the United States Health Service are listed according to rank, as in previous editions.

New information in the directory includes the certification of 4,000 additional physicians as specialists by the various American boards, data having been added on the

new boards covering plastic surgery and neurologic surgery. The American Board of Internal Medicine now also certifies candidates in the medical subspecialties of allergy, cardiovascular disease, gastro-enterology and tuberculosis. The American Board of Surgery now certifies specialists in the subspecialty of proctology.

The new directory contains 201,727 names of physicians. Since the publishing of the last directory 15,223 new names of recent graduates and physicians from abroad have been added. There were 8,656 names dropped from the directory since the last printing, principally on account of death.

According to information from the American Medical Association office, the new volume may be divided into three divisions; the first, covering national and interstate information; the second, lists information regarding hospitals and biographic data on physicians and the third, the alphabetical index of physicians.

Twenty-two pages are given to the physicians information and medical data of Kansas. Members of The Kansas Medical Society were listed as 1,583 in the 1942 directory, while in the 1940 directory the membership was 1,525.

The huge volume is indeed an undertaking, and in the many changes due to the present war situation, this publication problem has undoubtedly been tremendous. The American Medical Association has done a splendid job in the publication of this much-needed directory.

BLUE CROSS IN KANSAS

A steady advance in Blue Cross enrollment is reported by Sam J. Barham of Topeka, executive director of the Kansas Hospital Service Association, Inc.

Enrollment as of October 1 totaled 1,982 contracts representing 4,187 subscribers. There were 486 contracts representing 1,982 subscribers written during September. Several employee groups in Topeka and Hutchinson and one in Leavenworth came in during the month. Numerous cooperative associations in Reno county are recommending enrollment of their members.

Mr. John R. Stone of Topeka, president of the association, and Mr. Barham went to St. Louis the week of October 12 to attend the war conference of American and Canadian hospitals under the auspices of the American Hospital Association.

OKLAHOMA CITY CLINICAL MEETING

The list of speakers for the Oklahoma City Clinical Conference will be found on another page of this issue of the Journal. The meeting, which is to be held in Oklahoma City on October 26, 27, 28, and 29, is one that should be well attended by the members of the Kansas Society. With the announcement in this issue of the cancellation of the 1943 American Medical Association annual meeting, it is advisable for the profession to attend, wherever possible scientific meetings which are easily accessible to the state.

Physicians who are re-entering the service and those who must of necessity expand their professional duties or brush-up on the newer methods under the demands of a country at war, will find the meeting of great value.

Dr. Henry H. Ogilvie of San Antonio will discuss "Emergency Medical Service for Civilian Defense," a subject of great importance at the present time. Many other nationally known speakers will appear on the program.

It is hoped that many Kansas members will be able to attend the sessions.

NEW REGULATIONS ON COMMISSIONS

The office of Emergency Management, War Manpower Commission of Washington, D. C., released the following new regulations concerning granting of commissions to physicians, from the Surgeon General's office on September 9:

"The Surgeon General of the Army published detailed information concerning policies governing the initial appointment of physicians as medical officers on April 23, 1942. Necessary changes are given wide publicity, at his request, in order that the individual applicants, and all concerned in the procurement of medical officers, may know the status of such appointments.

"The current military program provides for a definite number of position vacancies in the different grades. The number of such positions must necessarily determine the promotion of officers already on duty and, in addition, the appointment of new officers from civilian life. Such appointments are limited to qualified physicians required to fill the position vacancies for which no equally well qualified medical officers are available. Such positions calling for an increase in grade should be filled by promotion of those already in the service, insofar as possible, and not by new appointments.

"If this policy is not followed, it would definitely penalize a large number of well qualified Lieutenants and Captains already on duty by blocking their promotions which have been earned by hard work. In view of these facts, it has been deemed necessary to raise the standards of training and experience for appointment in grades above that of First Lieutenant.

"With this in view, The Surgeon General has announced

the following policy which will govern action to be taken on all applications after September 15, 1942:

"All appointments will be recommended in the grade of First Lieutenant with the following exceptions:

"CAPTAIN.—1. Eligible applicants between the ages of thirty-seven and forty-five will be considered for appointment in the grade of Captain by reason of their age and general unclassified medical training and experience.

"2. Below the age of thirty-seven and above the age of thirty-two, consideration for appointment in the grade of Captain will be given to applicants who meet all of the following minimum requirements:

"a. Graduation from an approved medical school.

"b. Internship of not less than one year, preferably of the rotating type.

"c. Special training consisting of three years' residency in a recognized specialty.

"d. An additional period of not less than two years of study and/or practice limited to the specialty.

"3. Eligible applicants who previously held commissions in the grade of Captain in the Medical Corps (Regular Army, National Guard of the United States, or Officers Reserve Corps) may be considered for appointment in that grade provided they have not passed the age of forty-five years.

"MAJOR.—1. Eligible applicants between the ages of thirty-seven and fifty-five may be considered for appointment under the following conditions:

"a. Graduation from an approved school.

"b. Internship of not less than one year, preferably of the rotating type.

ANNOUNCING THE TWELFTH ANNUAL CONFERENCE OF THE OKLAHOMA CITY CLINICAL SOCIETY

October 26, 27, 28, 29, 1942

SEVENTEEN DISTINGUISHED GUEST SPEAKERS

DR. ISAAC A. BIGGER, Surgery, Medical College of Virginia.

DR. GEORGE M. CURTIS, Surgery, Ohio State University Medical School

DR. F. H. EWERHARDT, Physical Therapy, Washington University School of Medicine

DR. FREDERICK H. FALLS, Obstetrics, University of Illinois College of Medicine

DR. CHARLES C. HIGGINS, Urology, Cleveland Clinic.

DR. SARA M. JORDAN, Internal Medicine, Lohey Clinic.

DR. JOHN ALBERT KEY, Orthopedics, Washington University School of Medicine

DR. BYRL R. KIRKLIN, Roentgenology, Mayo Foundation, University of Minnesota

DR. ANDREW W. McALESTER, III, Ophthalmology, Kansas City, Missouri

DR. DONOVAN J. McCUNE, Pediatrics, College of Physicians and Surgeons, Columbia University.

DR. FRANK J. NOVAK, JR., Otolaryngology, Chicago, Illinois.

DR. ALBERT O. SINGLETON, Surgery, Medical Department, University of Texas.

DR. TOM D. SPIES, Internal Medicine, University of Cincinnati College of Medicine

DR. HOWARD C. TAYLOR, JR., Gynecology, New York University of Medicine.

DR. WILLARD O. THOMPSON, Internal Medicine, University of Illinois Medical School.

DR. EUGENE F. TRAUB, Dermatology, Post Graduate Medical School, Columbia University.

DR. JAMES E. PAULIN, President-Elect, American Medical Association, Atlanta, Georgia.

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"c. Special training consisting of three years' residency in a recognized specialty.

"d. An additional period of not less than seven years of study and/or practice limited to the specialty.

"e. The existence of appropriate position vacancies.

"f. Additional training of a special nature of value to the military service, in lieu of the above.

"2. Applicants previously commissioned as Majors in the Medical Corps (Regular Army, National Guard of the United States, or Officers Reserve Corps) whose training and experience qualify them for appropriate assignments may be considered for appointment in the grade of Major provided they have not passed the age of fifty-five.

"**LIEUTENANT COLONEL AND COLONEL.**—In view of the small number of assignment vacancies for individuals of such grade, and the large number of Reserve Officers of these grades who are being called to duty, such appointments will be limited. Wherever possible, promotion of qualified officers on duty will be utilized to fill the position vacancies.

"Much misunderstanding has arisen concerning recognition by Specialty Boards and membership in specialty groups. It will be noted that mention is not made of these in the preceding paragraphs. This is due to the variation in requirements of the different Boards and organizations. Membership and recognition are definite factors in determining the professional background of the individual, but are not the deciding factors, as so many physicians have been led to believe.

"The action of the Grading Board, established by The Surgeon General in his office, is final in tendering initial appointments. Proper consideration must be given such factors as age, position vacancies, the functions of command, and original assignments. All questionable initial grades are decided by this Board. Due to the lack of time, no reconsideration can be given.

"There are in the age group twenty-four to forty-five more than a sufficient number of eligible, qualified physicians to meet the Medical Department requirements. It is upon this age group that the Congress has imposed a definite obligation of military service through the medium of the Selective Service Act. The physicians in this group are ones needed now for active duty. The requirements are immediate and imperative. Applicants beyond forty-five years may be considered for appointment only if they possess special qualifications for assignment to positions appropriate to the grade of Major or above."

COMMITTEE ON LAND USE

The State Agricultural Planning Committee, which met in Manhattan on August 27-28, recently reported the minutes of the above meeting. Much of the material is non-essential to the medical profession. However, it is believed that the report submitted by the Health Sub-Committee is of interest to the members and is herein reported:

HEALTH SUB-COMMITTEE REPORT

"The health committee requests that the secretary send a letter to The Kansas Medical Association expressing appreciation for the services of Clarence Munns in past committee meetings and requesting their continued cooperation.

"The committee recommends that the Extension Service, through the Farm Bureau or county agents, push the Blue Cross Hospitalization service in the counties."

TIRE RATIONING FOR PHYSICIANS

The following bulletin of interest to the profession was mailed out of the central office on October 10:

"The State Rationing Officer and their attorney have recently come to me as your President because of a number of complaints received by them from different parts of the State alleging violation by various physicians of their privileges in the use of cars and tires. Some of these alleged violations are being investigated.

"I have assured the State Rationing Officer that the medical profession wishes to cooperate completely in limiting the use of cars and tires to permissible and necessary driving.

"He has furnished the attached bulletin of official information in regard to our privileges in the use of cars and tires which every physician should study carefully and carefully observe.

"Any violations of our privileges in the use of cars and tires will bring discredit to the entire profession and perhaps cause embarrassment and trouble to the violator.

"Firstly, for patriotic reasons alone and secondly, as a matter of self-interest, we should observe the enclosed regulations."

OFFICE OF PRICE ADMINISTRATION

"Due to the apparent confusion and reports as to physicians and surgeons using their automobiles equipped with rationed tires for ineligible purposes, we reproduce an explanation of Amendment No. 17, effective July 1, 1942, of the Tire Rationing Regulations (revised), as well as parts of other regulations that are pertinent to doctors.

"It is the purpose of the tire rationing program to insure the most essential use of our limited rubber supply. Further, it is felt that the persons to whom eligibility is extended in Sections 405 (a) and 405 (b), as amended—namely; a physician, surgeon, osteopath, chiropractor, farm veterinary or public health nurse, and regularly practicing ministers, priests, rabbis or other religious practitioners—could perform the service for which eligibility is extended as effectively by limiting the use of their vehicles to exclusive use for their professional services or religious duties. In this way, we can meet a substantial number of objections which have been made by members of the public as to the personal use of a car by a minister or doctor or by members of his family. For this reason, persons who are eligible under these Sections as amended may receive certificates for tires and tubes only when such tires and tubes are mounted on a vehicle which is necessary for the performance of professional or religious duties and is used exclusively in the performance of the specified services.

"Whereas the provisions under the previous regulations required only that the eligibles referred to needed and used motor vehicles in the performance of religious duties or to make professional calls when their professional practice required such calls, the present requirement is that the vehicle on which the tire or tube is to be mounted is necessary for the performance of the applicant's professional or religious duties because of the absence of other practicable means of transportation. However, in the case of a professional such as a physician or surgeon, if his professional practice requires his answering emergency calls, he may be issued a certificate to enable him to use his vehicle for transportation between his home, his office, or a hospital, even though other practicable means of transportation is available. Even in the absence of other practicable means of transportation, or in the event that the applicant's professional practice requires his answering

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* N. N. R. 1941, p. 328.

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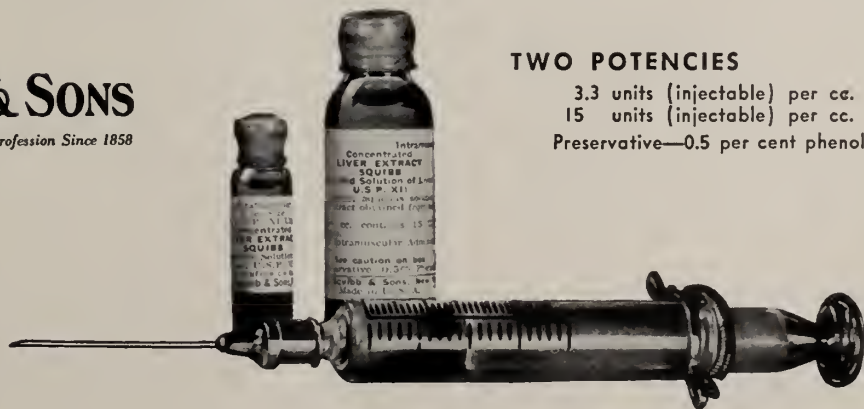
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emergency calls, the applicant must show that the vehicle is used exclusively for his professional duties.

"If the applicant has tires or tubes in his possession at the time of his application and the tires are still serviceable, and do not require immediate retreading or recapping, or the tubes can be repaired, he fails to establish that he needs tires or tubes at the time he makes application and he must be denied a certificate. On and after June 1, 1942, a Board may not issue a certificate for a tire to an applicant who seeks to replace a tire carcass which cannot be retreaded unless the applicant can establish to the satisfaction of the Board that the carcass which he seeks to replace became unusable from circumstances not resulting from the applicant's abuse or neglect. Granting or denial of a certificate under these conditions will be at the discretion of the Board with regard to the loss which the community will suffer if the applicant is denied tires. Where the community would suffer no serious loss if the applicant were denied tires, because other persons can provide the same service, or for other reasons, the Board may refuse to grant tires to replace such damaged tires."

"We wish to add that in order to be eligible an applicant must establish that if the vehicle to be equipped is a passenger automobile it cannot be replaced by another passenger automobile owned and operated by or subject to the control of the applicant which is equipped with serviceable tires or tubes, and which is capable of being but is not fully employed for one or more of the eligible purposes for which the tires were used."

"The question of whether a vehicle owned by the applicant's wife or other member of his family is subject to his control so as to render him ineligible for tires for his own vehicle, should be determined by the local boards on a factual, rather than a legal basis. A strong presumption that there is such control exists in the first instance, subject to be rebutted only by proof of an objective nature that in fact the use of the other vehicle has previously been unavailable to the applicant. Such proof might consist of a showing that the owner of the other vehicle uses it constantly for eligible purposes within the regulations. Previous use of the other vehicle by the applicant would strengthen the presumption that it was under his control."

"Very truly yours, H. O. Davis, State Director.

"Lloyd G. Gabbert, State Rationing Officer."

THE SCRAP DRIVE

Publications and publishers have been asked to aid in the national scrap drive now being conducted by the War Production Board Chief, Donald M. Nelson. Announcement has been made that more than eighty per cent of the nation's newspapers have pledged participation in the work of collecting scrap.

In the past two weeks the Journal office has collected and sent to the scrap obsolete cuts, used metal and other materials to assist the government in meeting the much needed scrap collection quota. Homes, farms, factories, and office buildings are all adding to the scrap heaps that are found in every school yard in the country. The home, being still the largest source of scrap metal, persons in every walk of life should feel it their duty to assist in this drive.

The monthly consumption of scrap metal is running about 4,000,000 tons, the largest in the history of the country, but this amount is not adequate to keep the nation's unprecedented steel production program in high

gear. Even this amount is not enough to manufacture the needed planes, guns, bombs, tanks and other necessities of war-fare for our American military forces and those of our allies.

NO CERTIFICATION OF PROSTITUTES

The American Social Hygiene Association, Inc., recently released the following information:

"At a meeting on June 9, 1942, at Atlantic City, the House of Delegates of the American Medical Association passed a resolution which will greatly aid in the fight against venereal diseases by placing the medical profession on record against the medical inspection and certification of prostitutes. The resolution was introduced by Dr. George Kosmak, a leading physician of New York City, well-known to the profession as the editor of the American Journal of Obstetrics and Gynecology. The reference committee to which the resolution was referred reported it favorably to the House of Delegates with the following statement:

'Your reference committee is completely in accord with the provisions of this resolution and recommends its adoption. It is inconceivable that any reputable physician should so degrade his profession and himself as to issue certificates to prostitutes, to the effect that they are free from venereal disease. This is a baneful practice which encourages the maintenance of vice and may do incalculable damage by giving false assurance of safety and lead to an appreciable increase in venereal disease. Moreover, it tends to nullify the efforts of the duly constituted authorities, Federal, State and local, to deal with the problems of prostitution by law enforcement and other accepted methods.'

'Your reference committee wishes only that it were gifted with the power of expression to emphasize more strongly its approval of the spirit and intent of the provisions of this resolution.'

"Other authoritative medical opinions on this subject have been expressed recently. The Public Health Council of the State of New York on November 28, 1941, expressed its views in part as follows:

'In the opinion of the Public Health Council, so-called "regulated" prostitution including a medical examination of prostitutes is as dangerous now as it has been in the past and will wherever practiced lead to increased exposures and increased venereal infection.' On December 1, 1941, the New York Academy of Medicine Committee on Public Health Relations stated that it 'wishes to record its opinion that commercialized prostitution is thoroughly untrustworthy as a method of venereal disease control.' A statement issued by the Council of the Medical Society of the State of New York was dated December 11, 1941, and was similar to the resolution later passed by the American Medical Association."

"It will be noted that the American Medical Association declares that 'physicians who knowingly examine prostitutes to give them medical certificates to be used in soliciting were participating in an illegal activity and violating the principles of accepted professional ethics.' In some states such practices are not only unethical but illegal. Thus, the laws of the State of New Jersey (Section 89-273i, Compiled Statutes 1910 with 1942 Cumulative Supplement): provide that no certificate of freedom from venereal disease shall be issued by any health officer or physician to any prostitute under any circumstances whatever. Similarly, laws of the State of Oregon (Chapter 320, Section 7, Oregon Code of 1930 with Laws of 1935) state

The Library of the Medical Department of the University of Kansas has every desire to be of service to the medical profession in the state. Any physician who wishes to avail himself of the facilities of the Library will be welcome both in the use of its periodicals, bound volumes of periodicals, and monographs and text-books.

Under certain circumstances, provided the volumes are not being actively used by the students, the Library will send such volumes as are needed to physicians in the state, on request, for a period of one week, provided carriage charges are paid both ways.

THE UNIVERSITY OF KANSAS SCHOOL OF MEDICINE

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1000.....	12	28.00	39.00

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that no certificate of freedom from venereal disease shall be issued by any health officer or physician or laboratory operator or other persons to any prostitute."

THE NEWTON EPIDEMIC

The Kansas State Board of Health was advised by the local physicians that on September 12, 3,000 persons in Newton were afflicted with an intestinal disorder.

After some investigation, the epidemic was found to be bacillary dysentery, often incorrectly called summer diarrhea or intestinal flu. The incubation period is a few hours to seven days and produces the following symptoms: generalized weakness, nausea, vomiting, dizziness, temperature, cramp-like pains in the region of the stomach, and bloody, frequent diarrhea. Individual cases of the disease persisted from twenty-four hours to seven or more days.

It was eventually established that the contamination came from the Mexican village, where the water mains were being repaired and these were near the water storage tanks of the city water supply.

The epidemic involved thirty-five per cent of the population of the city of Newton, and also may have been carried into many parts of the country, inasmuch as there are approximately twenty-three passenger trains through the town in a day, as well as troop-trains. It is known that many of the trains were supplied with water during the interval of the epidemic.

The disease is very contagious, and is usually spread through contaminated food, milk or water supplies. In this case the water mains had been disturbed and the epidemic resulted.

COMMISSIONS GRANTED

The Kansas Medical Officers Recruiting Board recently announced that the following doctors of medicine have been commissioned by that Board as of October 16. The list below is in addition to the ones published in the June, August, and September issues of the Journal.

NAME	ADDRESS	RANK
Floyd C. Taggart, Topeka.....		Captain
Leland P. Randles, Fort Scott.....		First Lieutenant
Oliver L. Martin, Baxter Springs.....		First Lieutenant
Ralph J. Rose, Kansas City.....		First Lieutenant
Gregg B. Athy, Columbus.....		First Lieutenant
Albert P. Condon, Whiting.....		First Lieutenant
Charles C. Underwood, Emporia.....		First Lieutenant

Albert Clark Baird, M.D., of Parsons, who had been tentatively rejected by the Board has been appointed in the grade of Captain by The Surgeon General.

BOARD OF HEALTH MEETING

The first quarterly meeting of The Kansas State Board of Health was held in Topeka on October 8. Members of the Board who were present are as follows: Dr. R. W. Urie of Parsons, Dr. Hugh A. Hope of Hunter, Dr. G. A. Leslie of McDonald, Dr. J. F. Gsell of Wichita, Dr. J. L. Lattimore of Topeka, Dr. H. L. Aldrich of Caney, Dr. G. I. Thacher of Waterville, Dr. R. T. Nichols of Hiawatha, and Dr. F. L. Loveland of Topeka. Dr. R. M. Sorensen, Director of Venereal Disease Control of the United States Public Health Department, a member of the lease-lend personnel, was a guest of the meeting. Dr. Sorensen is now on active duty in Kansas.

The Board discussed the proposed policies in regard to the following matters: venereal disease control in the state, photo-roentgen unit, the Newton epidemic, proposed post-graduate program, industrial hygiene, training of nurses on the Board in the Kenny treatment, war-time status of personnel of the Board, the merit system compensation plan, and the Blue Cross Hospital plan.

Action was taken on the above matter by the Board as follows:

1. The Board adopted a policy approving the use of the state laboratory as a case finding agency, for single tests only in venereal disease control but not for treatment. This however, does not apply in indigent cases, which are permitted to use laboratory facilities.

2. The Board continues approval of the policies recently accepted by The Kansas Medical Society Committee on Tuberculosis Control concerning the use of the photo-roentgen machine and that it be made available to the State as a whole.

3. A report in detail was given on the recent Newton epidemic. The Board approved cooperation with cities and towns on control of the water supply. A great deal of help and assistance was given by the Board in the recent Newton epidemic.

4. A post-graduate program for the state was discussed and the Board approved cooperation and assistance in this matter.

5. A bill was recently drawn up by members of the Board regarding public health service for cities and counties of the state. The Board approved the measure and it is being presented to the Research Department of the Kansas Legislative Council.

6. The Board approved the policy of the Division of the Industrial Hygiene cooperating with The Kansas Medical Society under the proposed program for the Committee on Industrial Medicine.

7. The Board discussed the possibility of sending the nursing personnel to Minnesota to learn the procedure of the Kenny treatment, and the possibility of increasing the bed capacity of the state hospitals in order that they may cooperate with the treatment of active cases of infantile paralysis and the proposal of general hospitals having beds for acute cases.

8. The Board discussed the merit system and the compensation plan, and the possibilities of waiving the age limit during the war emergency and other measures.

9. The Board discussed the Kansas Blue Cross Group Hospital plan under the Kansas Hospital Service Association, Inc., and established standards under which hospitals cooperating could be approved: The following are the standards:

a. A letter from the county medical society of the county in which the hospital is located to the effect that the hospital fills a community need.

b. A letter from the Kansas Hospital Association that the hospital fill a community need.

c. That the hospital is equipped adequately according to the size, needs, customs and practices of the community in which it is located, in accordance with the opinion of the Secretary of the Kansas State Board of Health.

CANCER DATA IN KANSAS

The Kansas State Board of Health recently released some interesting data on cancer to the members of the Society Committee on Control of Cancer.

The report, which it is believed will be of interest to members, includes cancer deaths as to site of lesions for

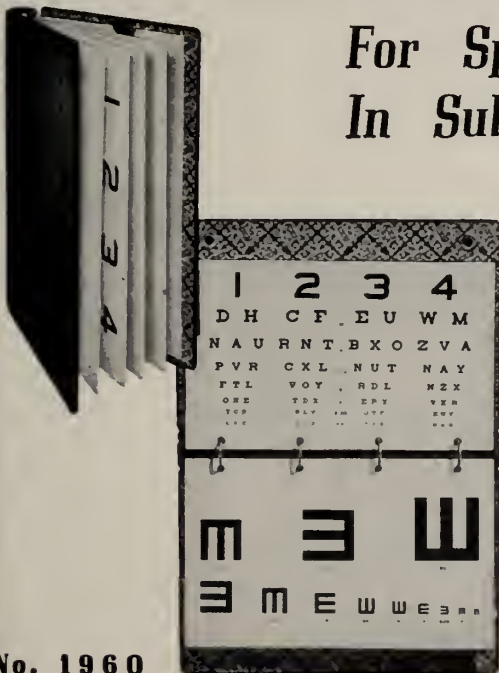


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a six months period from January to June for a nine years period as follows:

CANCER DEATHS AS TO SITE OF LESION

Six Months Period—January to June, Inc.

	1934	1935	1936	1937	1938	1939
Buccal Cavity and						
Pharynx	48	47	40	42	37	30
Digestive Tract	490	507	511	523	504	557
Respiratory System	26	25	33	42	36	35
Uterus	97	96	100	99	111	95
Other Female Genital						
Organs	23	18	18	28	30	23
Breast	96	83	103	101	111	119
Male Genitourinary						
Organs	99	118	101	103	109	115
Skin	38	33	44	32	28	33
Unspecified Organs	90	102	105	91	87	101
TOTALS	1007	1029	1055	1061	1053	1108

CANCER MORBIDITY REPORT

Six Months Period—

Jan. to June, Inc.....	47	32	32	35	37	78
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The report for the years 1940-1942 were not included in the first chart due to the fact that at that time the lesion data was sub-divided into eleven instead of the original nine subheads. The two new sub-heads being "Lesions of Urinary Organs" and "Lesions of the Brain".

CANCER DEATHS AS TO SITE OF LESION

Six Months Period—January to June, Inc.

	1940	1941	1942
Buccal Cavity and Pharynx.....	38	31	35
Digestive Tract	541	492	506
Respiratory System	41	41	66
Uterus	114	108	100
Other Female Genital Organs.....	30	35	33
Breast	109	113	126
Male Genitourinary Organs	92	88	68
Urinary Organs	48	47	47
Skin	40	29	26
Brain	16	16	15
Other and Unspecified Organs.....	54	78	93
TOTALS	1123	1078	1115

CANCER MORBIDITY REPORT

Six Months Period—Jan. to June, Inc.	82	110	82
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MINUTES

The following are the minutes of Society committee meetings held recently:

A joint meeting of the Officers, Councilors and the Society Committee on Public Policy was held in Wichita on September 20.

Members present were as follows: Dr. Henry N. Tihen of Wichita, Dr. J. L. Lattimore of Topeka, Dr. C. D. Blake of Hays, Dr. Marion Trueheart of Sterling, Dr. W. P. Callahan of Wichita, Dr. F. R. Croson of Clay Center, Dr. J. F. Hassig of Kansas City, Dr. Philip W. Morgan of Emporia, Dr. John L. Grove of Newton, Dr. R. R. Cave of Manhattan, Dr. Ben Mayer of Ellsworth, Dr. Herbert Atkins of Pratt, Dr. George O. Speirs of Spearville, Dr. E. C.

Duncan of Fredonia, Dr. F. L. Loveland of Topeka, Dr. C. A. Dieter of Harper, Dr. Hugh A. Hope of Hunter. Dr. L. J. Beyer of Lyons, Dr. L. V. Turgeon of Topeka, Dr. J. F. Gsell of Wichita and Miss Lane Skinner, Assistant Executive Secretary were also present.

Dr. Tihen opened the meeting by introducing Miss Jane Skinner the new Assistant Executive Secretary and Mr. Robert Brooks the new Executive Secretary.

Discussion was held on the policy of the organization as to legislative procedure.

Dr. Hassig read a letter that was submitted to the Little Legislature pertaining to the possibility of changing the medical school course to comply with war production needs, changing the specified dates of the meeting of the Board of Registration and Examination to another unspecified date in June, and the request that the registration fee for doctors of medicine be canceled for those in the military forces. On a motion made by Dr. Duncan and seconded by Dr. Callahan and carried the letter was approved.

Upon a motion made by Dr. Atkins the salary of Miss Miriam DuMars was raised ten dollars per month.

Dr. Trueheart moved, that The Kansas Medical Society pay the expenses of two members to the American Medical Association meeting of secretaries and editors to be held in Chicago in November.

Dr. Tihen then presented Dr. Theodore V. Oltman who has recently returned from China.

Adjournment followed.

A meeting of the State Committee on Procurement and Assignment was held in Wichita on September 20. Members of the committee who attended were as follows: Dr. F. L. Loveland of Topeka, Chairman, Dr. Henry N. Tihen of Wichita, Dr. C. D. Blake of Hays, Dr. C. S. Huffman of Columbus, Dr. W. M. Mills of Topeka, Dr. C. C. Nesselrode of Kansas City, Dr. Alfred O'Donnell of Ellsworth, and Dr. Marion Trueheart of Sterling.

A general discussion was held on the procurement and assignment situation in Kansas.

Dr. Loveland read a memo from the National Office of Procurement and Assignment, wherein he was asked to appoint several ex-officio members to serve in an advisory capacity to the Kansas committee. Upon a motion made by Dr. O'Donnell, seconded and carried, the Chairman was asked to make these new appointments. Dr. Loveland then named Dr. W. M. Mills as Vice-Chairman, Dean H. R. Wahl as Medical Education Adviser, Dr. F. C. Beelman as Public Health Adviser, and Dr. Charles Rombold as Industrial Health Adviser.

Adjournment followed.

A meeting of the Executive Secretary Committee was held in Topeka on September 13. Members present were: Dr. Henry N. Tihen of Wichita, Chairman, Dr. J. L. Lattimore of Topeka, Dr. F. R. Croson of Clay Center, Dr. Warren Bernstorf of Winfield, Dr. W. P. Callahan of Wichita, Dr. W. M. Mills of Topeka, and Dr. Marion Trueheart of Sterling. Miss Jane Skinner, as Assistant Executive Secretary, was also present.

A number of very well qualified applicants were interviewed for the position of Executive Secretary. It is the feeling of the committee that the qualifications of the applicants were unusually satisfactory.

After careful consideration, Mr. Robert Brooks of Winfield, was chosen for the position.

Adjournment followed.



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But Kansas needs to do more—because there is room for much more. If you know of a Kansas shop that can help, if you know of an industry that can logically locate in this state, get in touch with your Chamber of Commerce or the Kansas Industrial Development Commission. This is war—and we must seek out all isolated industries that might participate and attract all industries that might use our raw materials.

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MEMBERS

Dr. Harry J. Deeths of Atchison has recently been appointed as city health officer for that city.

Dr. Mary Elliott, formerly a member of the staff of the Larned State Hospital, has resigned to accept a position as resident physician in a hospital in Evansville, Indiana.

Announcement has recently been made of the appointments of two coroners. Dr. Herbert R. Schmidt of Newton has been appointed as coroner of Harvey County to succeed Dr. C. T. Sills, who recently resigned to enter the Army, and Dr. J. E. Attwood of La Crosse as coroner of Rush County to succeed Dr. J. H. Baker who also entered the Army recently.

Dr. H. L. Kirkpatrick of Topeka has recently been granted a commission as Captain in the Army Air Corps.

Dr. F. E. McCord, formerly of Topeka and health officer of Shawnee County, has been appointed as county health officer in Illinois, with offices in Jacksonville, Illinois.

Dr. S. N. Mallison of Augusta was elected president of the Kansas Public Health Association at the annual meeting of the organization held recently in Emporia. Dr.

Henry Asher of Topeka was elected as secretary and Dr. F. C. Beelman as the new treasurer of the organization.

Dr. J. V. VanCleve of Wichita retained the title at the Sixteenth Annual Golf Tournament, held in Wichita on September 18. Dr. VanCleve, with a score of 78, won from Dr. E. S. Edgerton, who followed with a 79. In the shooting, Dr. L. A. Sutter captured the Morrison trophy permanently having won it in 1939, 1940, and 1941.

COUNTY SOCIETIES

The Central Kansas Medical Society held its quarterly meeting in Hays on September 24. Dr. Ray M. Balyeat of Oklahoma City and Dr. D. C. Hines, representative of the Eli Lilly Research Clinic, were the speakers.

The Clay County Medical Society held the first fall meeting in Clay Center on September 17. A movie on "Traumatic Surgery" was shown.

The Douglas County Medical Society met in Lawrence on September 1. Dr. H. L. Chambers of Lawrence discussed the work of "The Douglas County Health Unit."

The Lyon County Medical Society held a meeting in Emporia on October 6. Dr. Thomas P. Butcher of Emporia presented a paper on "Severely Burned Patients." Dr. Butcher recently completed post-graduate work at the Lahey Clinic in Boston, Massachusetts.

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The Sedgwick County Medical Society recently decided to meet once a month for the duration of the war, the meeting being held on the first Tuesday of the month. The October 6 meeting of the organization was held in Wichita. Mr. Joe Creed, District Representative of the American Red Cross showed a movie entitled "First Aid Treatment for the Injured."

The Stafford County Medical Society held a meeting in St. John on October 7, at which time Dr. J. C. Ulrey of St. John was elected as Secretary to fill the unexpired term left vacant by the resignation of Dr. L. G. Graves. Dr. Graves recently entered the armed forces.

The Wyandotte County Medical Society held a meeting in Kansas City on September 15. Dr. Eldon E. Miller of Kansas City spoke on "The Aged Diabetic." Dr. Merle Parrish and Dr. P. M. Krall, both of Kansas City, discussed the paper.

ANNOUNCEMENTS

The Western Surgical Association has cancelled their annual meeting scheduled for December. However, the Executive Committee of the organization is holding a meeting in Chicago, Illinois, on November 20.

The American Academy of Physical Medicine will hold its scientific session in Boston on October 14-17. Discussions will include physical medicine in relation to aviation medicine, rehabilitation, first aid, and war injuries as well as many other subjects.

Announcement has been received in the office that the meeting of the American College of Surgeons which was scheduled for November 17-20 in Cleveland, Ohio, was

cancelled by the Board of Regents of the College at its meeting in Chicago on October 14.

BOOK NOOK

BOOKS REVIEWED

THE ART AND SCIENCE OF NUTRITION, A Text Book on the Theory and Application of Nutrition—Estelle E. Hawley, Ph.D., and Grace Carden, B.S., of the University of Rochester, School of Medicine and Dentistry of Rochester, New York. Published by the C. V. Mosby Company of St. Louis, Missouri. This book is one that should be in great demand due to the fact that nutrition, at the present time is one of the outstanding subjects of discussion. The principles of normal nutrition are herein discussed, with the fundamentals of nutrition and diet

DR. FINLAY SEES IT THROUGH—Alan Hart—published by Harper & Brothers, priced at \$2.50. Dr. Finlay returns from England to find the hospital which he had loved, smoke-blackened ruins. His struggle to bring progress out of the chaos of the depression years, to find the answer to socialized medicine, to fill his own life with some measure of peace after the early loss of his young wife, makes for an interesting story. There are also two other love stories running through the tale which reach a more or less satisfactory culmination.

NIGHT OF FLAME—Dyson Carter—published by Reynal & Hitchcock, New York, priced at \$2.50. This is a story described as "behind the scenes in a great hospital",

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* *Laryngoscope*, Feb. 1935, Vol. XLV, No. 2, 149-154
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60

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depicting the personal struggle of a young surgeon who is continually in conflict with numerous conflicting forces and his deep love for his work in a huge general hospital. It is a robust story, one which holds the reader's interest and satisfies the small-boy worship of fire apparatus and fire-fighting, which probably lurks in most grown men. The writer, a chemical engineer, fell into fiction writing by a rather unusual circumstance and has produced a novel which should meet with the approval of the public which likes its material couched in natural and boisterous language.

allergy, drugs, tobacco and foods. He delves into vitamin facts and their relation to health and to life. He discusses a balanced diet, digestion, elimination, constipation, the normal body weight and includes chapters on marriage, reproduction, the mind and the glands. The book ends with chapters on the attainment of long life. It is written for the general public with an informative, modern approach, in an interesting manner.

BOOKS RECEIVED

MERCHANTS IN MEDICINE—Emanuel M. Josephson, M.D., Fellow of the American Association for the advancement of Science; American Academy of Ophthalmology and Otolaryngology; Fifteenth International Congress of Ophthalmology; Acoustical Society of America, author of "Near-Sightedness Is Preventable," and "Glaucoma and Its Medical Treatment with Cortin." Published by the Chedney Press, 108 East 81st Street, New York, New York. Paper backed the volume is priced at \$1.50.

THE 1942 YEAR BOOK OF PHYSICAL THERAPY—Edited by Richard Kovacs, M.D., Professor and Director of Physical Therapy of New York Polyclinic Medical School and Hospital; Attending Physical Therapist of Manhattan State, Harlem Valley State and West Side Hospital; Visiting Physical Therapist of New York City Department of Correction Hospitals; Consulting Physical Therapist of the New York Infirmary for Women and Children, Mary Immaculate Hospital of Jamaica, New York and Hackensack Hospital of Hackensack, New Jersey. Published by the Year Book Publishers, Inc., of Chicago, Illinois. The book contains 416 pages, illustrated and is priced at \$3.00.

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IT IS YOUR LIFE—Max M. Rosenberg, M.D., formerly in charge of the Clinical Laboratory Department of Beth Israel Hospital, Clinical Assistant in Internal Medicine of Beth Israel Hospital and Clinical Assistant Pediatrician of Gouverneur Hospital. Published by the Scholastic Book Press, 158 East Twenty-Second Street of New York, New York, and priced at \$2.50. This is a book for the laity on how to keep healthy, stay young and live long. Dr. Rosenberg discusses such subjects as the periodic health examination, infection, immunity, hygiene of the body and of the home, fresh air, posture and exercise. He writes on

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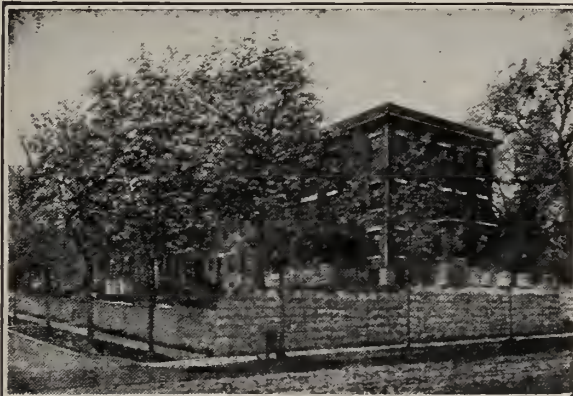
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Business Manager

AUXILIARY

PRESIDENT'S MESSAGE

My message to you this month will be devoted to transmitting some parts of our National President's inaugural address which was printed in the last issue of the Bulletin. Inasmuch as not all of you are subscribers to the Bulletin, though I hope you soon will be, I am taking this means to bring to your attention the tremendous task ahead of us.

It shall be our aim to see that one out of every six programs of the various women's clubs to which we belong shall be devoted to health education; to the end that the coming generation may not be deemed unfit for military service. We should combat in every way possible the false impression that physical defects, found in our selective service inductees, were in any way a neglected responsibility of the medical profession.

It is more important than ever before that this year Hygeia be placed in public schools, camps, libraries and homes. Nothing is so malleable as youthful imaginations and ideals. Let us guide our youths in the right directions.

We must keep a watchful eye on falsely premised legislation while our husbands are so busy. Do not drop your membership in the Auxiliary for the duration if your husband is in service, for it is only through such membership that you may keep in contact with your husband's chosen profession. If our interest in Auxiliary work lags through this crisis, it will take many years to build back to our original strength. Instead, we should be stronger and more closely knit together when the war is over, and ready to help in the tremendous task of rehabilitation.

Our recently appointed State Program Chairman, Mrs. J. W. Randell of Marysville has some excellent material for programs at your county meetings. Be sure to take advantage of it.

It may be that restricted mileage and gasoline rationing may have some effect on the attendance at Auxiliary meetings, particularly in the western part of the state. If this is so, keep up your contacts through our Kansas Journal, our Auxiliary News Letter and the National Bulletin. If your work in Red Cross, nurses' aid, etc. has taken so much of your time you feel you must drop your membership in some of your clubs, do not let it be the Auxiliary. Any woman can belong to most clubs, but only a doctor's wife may belong to the Auxiliary and she should feel it is her duty and her privilege to work in it.

Most of you are getting ready for your first meeting after the summer's vacation. I shall be thinking of you and wishing you all kinds of success. All the state chairmen and I stand ready to help you at any time in any way. I do hope you call on us if you have any special problems.

Mrs. C. Omer West.

AUXILIARY NEWS

The Woman's Auxiliary to the Marshall County Medical Society held a meeting in Frankfort on September 17. The organization decided to assist in the surgical dressing rooms of the Red Cross instead of holding the usual meeting.

The Woman's Auxiliary to the Shawnee County Medical Society held a meeting on September 14 at the home of

Mrs. J. L. Lattimore, in Topeka. The October 12 meeting of the organization was held at the home of Mrs. L. A. Curry in Topeka.

School Bus Ambulances—Blairstown, New Jersey, has converted with satisfaction and economy their school buses into ambulances, and Frank S. Gordon, M.D., has contributed a description with estimated costs and construction plans for such conversion. Those interested can obtain information by writing to Dr. Gordon, Blairstown.—Journal of the Medical Society of New Jersey.

CLASSIFIED ADVERTISEMENTS

FOR SALE—Office equipment of retiring physician engaged in general practice. Located in good college town of fifteen thousand, in Kansas. Address Journal c/o X.

FOR SALE—Entire office equipment, including instruments and files, of Eye Ear, Nose and Throat Specialist. Collections last year over \$10,000. Growing town of 20,000. Write Journal of The Kansas Medical Society C-0-4.

FOR SALE—Complete x-ray outfit, including two Coolidge tubes, Potter-Bucky diaphragm, and many accessories. Price \$67.50, less than the tubes alone cost. Write C-02.

FOR SALE—Complete equipment of modern clinic including: Standard x-ray unit, tilting Bucky table, Fluoroscopic Screen, Sanborn Basal Metabolism Unit, Radio Diathermy, Bausch & Lomb Microscope, surgical cabinet, 2 operating tables, instrument tray, 3 electric sterilizers, 2 examining tables (wood), hospital bed, office desks, and many other items. No reasonable offer refused, write C-0-5.

FOR SALE OR RENT—Equipped office, four-room building, for general practice in town of 1,400, south-central Kansas, for sale or rent. Write for details to T. J. Thomas, M.D., Veterans Administration Hospital, Waco, Texas.

FOR SALE—Entire ultra-modern medical equipment of the late Dr. Harrison B. Talbot for sale—Address Journal of The Kansas Medical Society, C-03. Mrs. H. B. Talbot, 600 West Eleventh Street, Apt. No. 6, Topeka, Kansas.



BUY
WAR
BONDS
AND
STAMPS

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FUNDAMENTALS OF PSYCHIATRY II

William C. Menninger, M.D.

Topeka, Kansas

THE HISTORY OF PSYCHIATRY

The knowledge of the history of any subject is of major importance to the student of that subject. It is only from history that we can see our foibles and our mistakes and it is from the knowledge and scrutiny of these that we make progress. Through a historical survey of a field one many become oriented in relation to its present status.

From the point of view of psychiatry a study of this history of the subject throws much light upon the origin of the many misconceptions regarding it, misconceptions that extended far beyond the field of mental illness. The history of psychiatry represents an important phase of the history of mankind and in studying it one becomes involved in the history of philosophy, religion, science and many other struggles of man in which he has expressed his mysticism and credulity.

In the development of medicine, psychiatry has lagged far behind most other specialties. Perhaps the chief factor in this sluggish development was the influence of religion which obscured psychiatry for at least fifteen centuries after Christ. The lack of anatomical knowledge and the intangibility of mental concepts and careful study of them as such, made this period almost sterile of any scientific studies or understanding of mental illness. The symptoms of the mentally-ill individual, primarily as a result of religious influence, proved to be fertile soil for the development of superstitions, of magic, of witchcraft, and of taboos. Between the period of the Greeks and 1750 A.D. there was an academic rigidity of thought which prevented the development of what we now call scientific open-mindedness and particularly did this factor prevent the development of understanding of mental disease.

THE STAGES OF DEVELOPMENT

Every historian arbitrarily divides the eras of the development of his subject to suit his own purpose.

In the various historical summaries of psychiatry hardly any two writers use the same ages. In this presentation, for the sake of brevity, I have divided the history into five periods: the Ancient Era from 2500 B.C. to 200 A.D.; the Christian Era from 200 A.D. to 1500 A.D.; the Reformation and Renaissance from 1500 A.D. to 1750 A.D.; the Era of Enlightenment from 1750 A.D. to 1890 A.D.; and the Modern or Analytic Era from 1890 to date.

Ancient Era:—The prevalent attitude through this era 2500 B.C. to 200 A.D. related all forms of sickness to the gods, so that various races of mankind regarded sickness as some sort of an expression of the will of the gods. The Assyrians worshipped natural forces. The Egyptians created gods who were skilled in the art of healing. The Jews regarded disease as the wrath of God, a punishment for sin, and believed that healing was to be obtained through sacrifice and by prayer to the Lord. The Greeks regarded mental disorders as infestations of the gods, so that the better-behaved sick individual was venerated as a demi-god, and the less well-behaved as possessed of evil gods.

The important characters related to psychiatry in this period included first Pythagoras (582-504 B.C.). This famous Greek regarded the brain as the organ of higher activities and in an attempt to treat mental illnesses advised special dietary measures and the leading of a moral life in which moderation and occupation were essential features. Hippocrates (460-370 B.C.), usually regarded as the father of medicine, was among the first to deny the sacred origin of disease and believed it to be due to natural causes. He described deliria, mania, melancholia and dementia, each of which was supposed to be caused by disturbances of which he called "humors." The four "humors" were yellow and black bile, blood and mucous. It was he who first described hysteria as being due to a wandering of the uterus, believing that it occurred only in women, and that its pressure on various parts of the body caused the symptoms.

Plato (428-347 B.C.) and Aristotle (384-322 B.C.) were both philosophers and necessarily interested in the mental life of man. Both maintained but did not advance the understanding of mental disorders beyond the teachings of Hippocrates. In

fact, Aristotle perhaps went backwards somewhat as judged by such conceptions as that the soul was located in the heart. Galen (131-201 A.D.) was very religious and somewhat more philosophical in his viewpoint than Hippocrates and certainly less factual. He described much of the anatomy of the brain, however, including the ventricles, a portion of the sympathetic system and seven of the cranial nerves. He believed that the blood contained "natural spirits," that the liver contained "vital spirits," and that the brain converted these into "animal spirits." He distinguished between physical and mental causes of mental disorders.

Throughout this era the treatment of mental illness was limited chiefly to incantation, sacrifice, prayers and purification. The Greeks instituted bleeding and purging as therapy but they relied also on diet, exercise and education. They strongly advocated prophylaxis and in general reached the stage of development which was more progressive than any time during the next fifteen hundred years.

The Christian Era—200 A.D. to 1500 A.D. The attitude toward mental illness during this period of man's history was one of mysticism and religiosity. Religion had replaced science with a concomitant decline in civilization. It was considered that the body was of no importance in comparison to the spirit and the soul. The senses were distorted or ignored. Man was the prize of demons and his soul was the battle ground between the devil and the Lord for its possession. He was supposed to frequently become possessed by animals (known as lycanthropy), or often he was actually turned into a beast (known as a werewolf). Mystical figures and forces known as vampires, devils and witches flourished. During a period of a few years 6,500 people were executed for witchcraft in one small Prussian city, Treves, with a population of 49,000.

During this era many important events transpired. It was the age of devastating epidemics—cholera, the plague (known also as Black Death), leprosy, and scurvy. Religious movements ran rampant and included such freakish performances as the Children's Pilgrimages, where children were encouraged to march thousands of miles, the Holy Wars and the Crusades in which hundreds of thousands lost their lives attempting to find the Holy Grail. There were epidemics of flagellation (whipping), chorea and tarantula dances, all in the name of religious zeal.

It was during this era that a monastic institution known as The Priory of St. Mary of Bethlehem was started in 1247. When mental cases were first admitted to this institution was not recorded, but the place was referred to in 1330 as a hospital. In 1547 it was given to the city of London as an asylum for housing fifty "lunatics." Since that time it has twice

been moved and now is known as the Bethlem Royal Hospital, a psychiatric institution of about 500 beds.

Important characters, so far as the history of psychiatry during this era is concerned, are conspicuous because of their absence. Only one, Johannes Weyer (1515-1588) stands out. It was he who, although a very religious man, instituted the observational and testing methods of human behavior. Through his courageousness he was the first to include behavior disorders (the field we now regard as psychiatry) as a part of medicine. Much of his work was done in opposition to a publication by two Dominican friars known as the "Witches Hammer." This book was a guide for the inquisitors and gave in detail the behavior, symptoms, method of conviction and the punishment of witches.

The treatment during this era consisted almost entirely of cruelty, the predominating form being whipping, torture, burning, chaining, confinement in dungeons, starvation and death by various methods. During the latter 200 years a group of individuals known as mystics and astrologers appeared and grew in importance. With them treatment was controlled by the signs of the zodiac.

The Reformation and Renaissance—1500 to 1750 A.D. The attitude toward mental disease during this period was a triangular conflict between the priests who regarded themselves as physicians of the soul, the philosophers (like Kant 1724-1804 and Descartes 1596-1650) who regarded themselves as best fitted to understand human thought, and the physicians, who were beginning to include mental illnesses as a part of medicine. The religious influence which had permeated the attitude and behavior of mankind in previous years gradually waned, primarily because of advance of science in general and the spectacular discoveries of such men as Galileo (1564-1642), Kepler (1571-1630), Newton (1642-1727), Harvey (1578-1657), Haller (1708-1777), and Leeuwenhoek (1632-1723).

This era saw the starting of mental hospitals. The first epileptic hospital was started in Alsace in France in 1486 but at this time the disease was regarded as contagious. Mental asylums, so called, began with Bethlem in 1547, St. Lukes in England in 1751, the Pennsylvania Hospital in Philadelphia in 1752, the famous psychiatric institution in Moscow in 1764, and the still standing Narrenturm in Vienna in 1784.

Of the important characters in this era contributing to psychiatry, at least four should be mentioned. A man who became known as Paracelsus, whose real name was von Hohenheim (1493-1541), was a curious mixture of physician, astrologer, alchemist, as well as being an eccentric and a drunkard. He believed that disease was caused by some influences

from the stars and was perhaps the first to suggest that magnetism was concerned with disease.

The outstanding figure of this period was Andreas Vesalius, who inaugurated significant reforms in the study of anatomy. He demonstrated the physiology of muscle-nerve preparations, made observations on the skulls of the different races, and insisted that the cerebral activity of the lower animals was similar to that of man. He published his "*De fabrica humani corporis*" in 1543, in which he presented excellent cross sections of the brain and the nervous system. Franciscus Sylvius (1614-1672), who was primarily an anatomist, advocated psychiatric treatment with drugs and moral persuasion. Felix Plater (1536-1614) attempted to systematize and classify mental disease, perhaps the first effort in this direction, and in so doing distinguished between acquired, congenital and hereditary disease. George Ernest Stahl (1660-1704) attempted to construct a theoretical system of animism with the soul as the seat of animal life in man, and interpreted symptoms as attempts of the soul to rid itself of morbid influences.

Treatment during this period consisted primarily in segregation of patients, with attendants who were little more than convict keepers, providing the poorest of food, straw beds, and vermin infested cells. The patients were usually kept in chains in unlighted, unsanitary cells and without medical treatment. In a few instances, it was given by purging, blood-letting and starvation. The idea persisted that mental illness was some sort of an infestation and as a result the patients were treated by putting them in whirling machines, by surprise baths, unexpected noises, or offensive odors for the purpose of driving out the demon. The more mildly ill ones were permitted to wander the streets and beg alms.

The Era of Enlightenment—1750 to 1890. There was a gradual change in the attitude in this period which first manifested itself in the method of care by hospitalization, and later by an intensive effort to study the delineation and classification of mental disorders. It was during this era that mental sickness came fully into the realm of medicine, though the knowledge and understanding and application gained in psychiatry was limited largely to institutionalized patients.

The important events of this age in the advancement of psychiatry centered around the formulation of what was called the "open-door" policy, the widespread agitation for reform, the organization of various psychiatric groups and the contributions toward the description and classification of mental disease.

The "open-door" policy, so-called, was a change from the previous "mad-houses" and "asylums"

where the patients had been chained in dark unsanitary cells, to comfortable, lighted, sanitary rooms, with a simultaneous discarding of chains and of tortures. This movement was instituted first in France by Philippe Pinel (1745-1826) in 1792, who brought about this reform against great opposition while a physician at the Bicetre. Almost simultaneously, and certainly independently, a non-medical man, William Tuke, in 1794 raised funds for what was called the "retreat" for members of the Friends' Society in England, in which restraint was abandoned and occupational activities were provided. Much credit is given to Benjamin Rush (1745-1812) in the United States who opened the Pennsylvania Hospital for mental disease in 1751, although for many years Rush used antiquated methods of treatment, including one of his special devices known as the tranquilizing chair for the disturbed patient; in this the patient's wrists, body and ankles were strapped, and his head enclosed in a box. The first state institution was opened in Virginia in 1773, followed in 1791 by New York Hospital which later became Bloomingdale, and the Maryland Hospital in 1798, which was the beginning of Johns Hopkins Hospital.

In addition to Pinel and Tuke, a Massachusetts school teacher, Dorothea Lynde Dix (1802-1887) carried on extensive reform agitation. She spent a tremendous amount of effort, traveled all over the United States and went to Europe, to lecture, organize, and plead for legislation for the construction of mental hospitals. She is credited with the establishment of thirty-two mental institutions as a result of her efforts. In France Jean Esquirol (1772-1840) headed an investigation committee of asylums in 1838 which led to a radical reform of the management and care of psychiatric patients throughout France.

For the first time various individuals interested in psychiatry came together to exchange ideas and organized groups began to appear. The American Psychiatric Association started with the association of thirteen medical superintendents of state institutions in 1844. The British Association started in 1864. A Dr. Campbell Clark in England in 1880 wrote a Handbook for Attendants of the Insane, and Dr. Edward Cowles is given credit for having started the first training school for nurses in psychiatry at McLean Asylum in Massachusetts in 1879.

Many characters were outstanding in their contributions to psychiatry during these years. Among the English psychiatrists who flourished in the Age of Systems, none is more justly esteemed than William Cullen (1712-1790). He was a most eminent and popular Professor of Medicine at Edinburgh. He founded a comprehensive system, based on the new

physiological doctrine of irritability, special importance being attached to nervous action. His classification of diseases was needlessly complex, although several of the main divisions are still preserved. He emphasized that in mental diseases the ultimate cause was endogenous; taught that insanity was not a visitation from without, but that its symptoms must be interpreted in terms of normal psychic functions; contributed much to the systematizing of the psychoses; stated that insanity was a morbid condition of the mind, and advocated as little restraint as possible.

Franz Anton Mesmer (1734-1815) revived the hypnotic idea of Maxwell, Helmont and Kircher under the guise of animal magnetism. He held notorious seances in Vienna and Paris, but was forced to leave both places as a fraud, after being investigated. He was very spectacular, always appearing clad in a lilac suit, and waved a magic wand, with which he touched his patients, as they joined hands around magnetic tubs, which contained a mixture of hydrogen sulphide and other ingredients, and which were provided with iron conductors, from which depended a ring for purposes of contact. Mesmerism is of importance in connection with the history of psychiatry because it introduced a new note into mental therapy, and it was partly responsible, at least, for psychic influence becoming such a potent factor in the causation and treatment of the psychoses.

Mesmerism, was first used as a means of anesthesia in surgery by John Elliotson (1791-1868). (Elliotson also has the distinction of introducing the use of potassium iodide and also the stethoscope into England.) James Braid (1795-1861), also a surgeon, coined the word hypnotism in 1841, using this method in surgery. Wilhelm Griesinger (1817-1868) furthered the understanding of psychiatry greatly through his researches which were published in 1845 in a book known as the "Pathology and Therapy of Psychic Disorders." Jean Martin Charcot (1825-1893), a great French neurologist, contributed to psychiatry through his description of hysteria as a physical representation of an idea, which he showed to be influenced by hypnosis, but explained the cause of the illness as due to a type of organic defect in brain structure.

During this period various psychiatric diseases were first described and named. While the ideas and understanding of these various illnesses have changed markedly from their original descriptions, these descriptions indicate the progress in the delineation of various types of mental pictures: general paralysis was described by Cameil in 1826; moral insanity by Pritchard in 1835; circular insanity in 1853; hebephrenia in 1863, catatonia in 1874, both by Kahl-

baum; and neurasthenia by George Miller in 1869. Emil Kraepelin (1856-1926) who is generally regarded as the father of descriptive psychiatry, and certainly as the greatest of descriptive psychiatrists, contributed monumental advances. He described and defined his concepts of dementia praecox, paranoia and paraphrenia. He combined and described mania and depression as the manic-depressive psychosis. His work extended over this period as well as into the next period.

There are two other outstanding characters whose contributions also began in this era and continued somewhat into the next. S. Wier Mitchell (1830-1914) a Philadelphia psychiatrist, who instituted what became known as the "rest treatment" for nervous patients, consisting chiefly of a planned program of mild activities, careful dietary supervision and much bed rest. Eugene Bleuler, a Swiss psychiatrist, (born 1857) added much to our understanding of psychiatry through various contributions. He described schizoid and syntonetic personalities, defined the concept of ambivalence, described autistic thinking, coined the term schizophrenia and described the illness.

The treatment of illness during this period changed markedly. At first, there was an implicit trust in drugs, which if unsuccessful, were followed by hard knocks and cruel treatment. Then began the introduction of psychotherapy, first in mesmerism, and later in its scientific use in hypnotism. Alms houses and jails progressed into asylums and abandoned the use of chains to adopt an "open-door" policy, in which rest, seclusion and occupation were important advances.

The Modern or Analytic Era—1890 to date. Psychiatry has made more progress in the last fifty years than it did during the previous eighteen centuries. In general, the attitude changed during this period from an interest in merely the description and classification of mental disease to an investigation of the psychic and physical causes. This might be summarized as a change from an interest in "what" to "how." The chief impetus for this change and the direction it has taken have been derived from the researches of psychoanalysis as instituted by Freud. Conspicuous has been the change from the "asylum" to the hospital, which includes not only the significant change in attitude, but also differences in the actual management and treatment suggested by these two concepts.

Various approaches to the understanding of mental phenomena have appeared during this period. Clinical psychiatry has contributed much through psychotherapy based on suggestion. This was instituted originally largely through two Frenchmen, Liebeault and Bernheim (1823) of Nancy, who used

hypnosis extensively and regarded it as a form of suggestion. They were followed by another Frenchman, Janet (1859) who contributed the ideas of psychasthenia and dissociation, though he did not recognize the existence of an inner conflict. A school known as "Experimental Psychology" was formulated by Wilhelm Wundt (1832-1920) which attempted to explain behavior in terms of neural mechanisms. Two Russians, Bechterew, and more conspicuously, Ivan Pavlov (1849-1936), contributed a great deal of understanding through the study of what they called conditioned reflexes, namely, a physiological response to a secondary stimulus, i.e. a stimulus which primarily was not capable of producing the response. Emphasis on the constitution and the relation between body types and mental reactions has been particularly stressed by Kretschmer. In the United States Adolph Meyer (born 1866) proposed an approach to the study of mental disorders which he called "psychobiology," a concept which regarded the individual as a whole, as a functioning unit, any part of which may break down and influence the functioning of the total individual.

Undoubtedly the most outstanding contribution has been that of Sigmund Freud (1856-1939) through what is known as psychoanalysis, a psychological concept of the etiology, development, and the treatment of neuroses which is equally applicable to the understanding of the psychoses. As basic tenants in his thesis are the concepts of the unconscious, of repression and of an infantile emotional life. Offshoots from Freud's original school of psychoanalysis have been numerous. The most important of these are Carl Jung's (b-1875) "Analytical Psychology," and Alfred Adler's "Individual Psychology." Jung discarded the concept of the sexual libido of Freud for what he called the "universal force," and also discarded the dynamic unconscious for what he prefers to term a "racial or collective unconscious and an individual unconscious." Adler has entirely denied the existence of the unconscious, as well as infantile sexuality and repression; for these, he has in some degree substituted "organ inferiority," the "masculine protest," and the "will to power," as significant etiological factors.

In addition to psychoanalysis, another important point of view began in this era, the Mental Hygiene Movement which developed through the efforts of a layman, Clifford Beers, who in 1908 published his autobiography, "A Mind That Found Itself." This document is an account of his own experiences as a psychiatric patient in several mental hospitals. He enlisted the aid of psychiatrists, lawyers, clergymen and other outstanding citizens to institute first a local Mental Hygiene Movement, and then a National Movement, which has now become Interna-

tional. The Mental Hygiene Movement has been followed by the formation of the Child Guidance Movement, the invasion of psychiatry into industry, and the introduction of psychiatric methods into criminal and juvenile courts and penal institutions.

Treatment during this era can hardly be summarized. The great advance has been through psychotherapy, particularly psychoanalysis and its various offshoots. Occupation, recreation and education have been introduced as therapeutic procedures and not merely as time-consumers or amusements. Unfortunately, the great majority of state hospitals are still limited for economic reasons to diagnosis and custody, though there are many brilliant exceptions and almost all instances there has been a very marked improvement in the living conditions of the individuals in these institutions.

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"Relativity" With Apologies to Einstein—Even a fact can be more or less significant. In the last World War, we were told that "one-third of the flower of our youth was defective," but we won that war, and it is quite likely that there were many more defective soldiers in the other wars won by our country. Better methods naturally increase our skill. We are again warned that "the draft examinations show a still higher degree of defective youths," but many of the early rejectees will be in there fighting effectively beside the more perfect specimens before we are again at peace. Quality is associated with quantity.

Minor defects are quite prevalent among the public, even when their presence is known to those affected, and the means are available for their correction. This is a plea for better interpretation of the true significance of certain statements in order that the presentation of facts shall not defeat the purpose for which they were presented. Perfection is an elusive goal toward which we approach slowly, and voluntarily by preference.—*Journal of the Medical Society of New Jersey*.

In Government Service—The total numbers of physicians employed in some form of government service as of July, 1940, was 9,819, but this number is thought to have changed considerably in the last two years. In public health there were:—United States Public Health Service, 1,789; state health departments, 1,410; local health departments, 2,341; Veterans' Administration, 1,779; Indian Field Service, 910; other federal agencies, 2,293.

In hospital service there was a total of 16,457 physicians; in hospital administration, 3,089; as residents, assistant residents and fellows, 6,149, and as interns, 7,219.—*Minnesota Medicine*.

APPENDICITIS IN ST. JOHN'S HOSPITAL*

John C. Mitchell, Lt., M.C., U. S. Army

Salina, Kansas

Since it has been reported by competent observers that the highest appendicitis death rate occurs in two regions, the Rocky Mountain and the Central Plains region, and inasmuch as Kansas borders one of these areas, the writer felt that a report on the mortality rate of a small general hospital would be of interest and value.

The date of this report of 250 consecutive appendicitis cases is taken from the admission to St. John's Hospital, Salina, Kansas. Only cases are given which were diagnosed and operated as cases of acute appendicitis. No cases were reviewed in which the appendix was removed during another operation. This report covers the years of 1940 and 1941 and a few cases from 1942. The author feels it is of especial interest since the widespread use of the sulfa group of drugs has taken place during this period. The cases were broken down and the data reassembled in order to present as true a picture of the surgery done in the locality concerned as compared with teaching institutions in various parts of the country.

AGE GROUPS

The age groups were arbitrarily divided into several groups. The groups were one to ten years; ten to fifteen; fifteen to twenty; twenty to twenty-five; twenty-five to thirty; thirty to forty; forty to fifty; and over fifty years. The oldest patient was sixty-

fifteen to twenty years and twenty to twenty-five years. In the fifteen-twenty age group there were sixty-eight cases or twenty-seven per cent and in the twenty to twenty-five age group there were sixty-five cases or twenty-six per cent. Eighty per cent of the cases were under thirty years of age. The cases in the other groups were as follows: one to ten group twenty-one cases; ten to fifteen group, twenty-three cases; twenty-five to thirty group, thirty cases; thirty to forty group, twelve cases; forty to fifty group, eighteen cases; and over fifty years, thirteen cases or 5.2 per cent.

In the cases that died it is interesting to note that four of the five deaths occurred in cases over forty years of age.

INCIDENCE ACCORDING TO SEX

Out of the 250 cases, there were 130 males or fifty-two per cent.

HISTORY—CATHARTICS

In spite of the extensive advertising campaigns which have been conducted against taking a laxative when you have pain in the abdomen, there were forty-five cases, or eighteen per cent, which gave a history of having taken a laxative, while sixteen of the twenty-two ruptured cases or seventy-three per cent had taken a laxative.

ONSET

One hundred eleven cases or forty-five per cent had an onset with generalized abdominal pain, and 112 cases or forty-five per cent complained of an onset of pain in the right side so according to this series the onset was evenly divided. There were only twenty-seven cases which had the typical onset of epigastric pain.

NAUSEA AND VOMITING

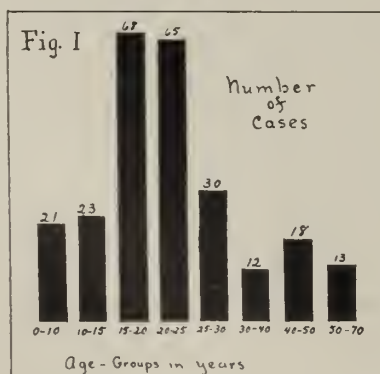
One hundred thirty-four or fifty-four per cent had both nausea and vomiting while fifty-nine cases or twenty-three per cent complained of nausea alone which leaves fifty-seven cases with neither nausea or vomiting.

DIARRHEA AND CONSTIPATION

In 195 cases there was no history of change in bowel habit, while in forty cases or sixteen per cent there was a history of constipation and in only fifteen cases or six per cent was there a history of diarrhea.

DURATION

The cases were divided into the following groups. Less than twelve hours; twelve to twenty-four hours; twenty-four to forty-eight hours; forty-eight hours to one week; over one week and recurrent attacks. If you take forty-eight hours as the maximum period of time to elapse before operation, then 113 cases or forty-five per cent fall in this group. The largest



seven years of age and the youngest was four years of age. The highest incidence occurred in the age groups

*The author wishes to express appreciation to the Board of Governors of St. John's Hospital of Salina for the privilege of reviewing the records of the Staff, and to Sister M. Carmella who is in charge of the records, for her willing help.

number of cases fell in the twenty-four to forty-eight hour group with fifty-five cases or twenty-two per cent. In the less than twelve hour group there were twenty-nine cases; twelve to twenty-four hour group, thirty-one cases; forty-eight to one week, fifty-one cases or nineteen per cent; forty-nine cases or nineteen per cent were older than one week and thirty-five cases were listed as recurrent attacks. Of the patients operated in less than twelve hours, there were thirteen cases listed as simple acute, five cases as empyema of the appendix, and four ruptured according to the pathological report, making seventy-six per cent of those operated in the first twelve hours having acute appendicitis. Of the recurrent cases ten were listed pathologically as acute at time of operation, making thirty per cent of the recurrent cases acute.

PHYSICAL EXAMINATION

One hundred seventy-six cases or seventy per cent had some muscle spasm of the right rectus with muscle guarding and rigidity over McBurney's point. Seventy-four cases had only tenderness over McBurney's point; every case thus had localized tenderness of some form or other.

VAGINAL EXAMINATION

Of the 120 females who were operated there were fifty cases or fifty-four per cent which had a vaginal examination prior to examination. This number excludes those under thirteen years of age.

ADMISSION NOTES—TEMPERATURE

These were subdivided into below normal; normal; 98.8 to 99.6; 99.6 to 100.6; 100.6 to 101.6; and over 101.6. The largest group fell in the 98.8 to 99.6 range with ninety-one cases or thirty-six per cent. The next largest group was below normal with fifty-five cases or twenty-two per cent.

The next group was those with normal temperature with forty-nine cases; group 99.6 to 100.6 with

twenty-one cases; 100.6 to 101.6 group with eighteen cases and the group of over 101.6 had sixteen cases. The lowest temperature was 96.4, while the highest was 103.6 in a ruptured case. Of the acute cases there were twenty with below normal temperature, and eighteen cases with normal temperature; also three of the ruptured cases had a below normal temperature.

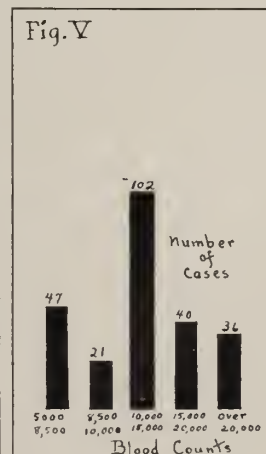
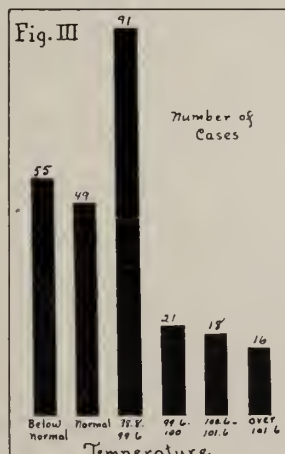
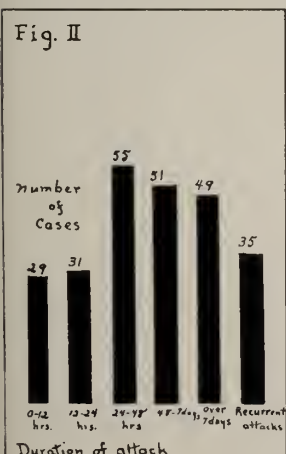
PULSE

Pulse rates were divided into groups as follows; fifty to sixty group, three cases; sixty to seventy, thirty-four cases; seventy to eighty, seventy-two cases; eighty to ninety, fifty-eight cases; ninety to 100, fifty-three cases; over 100, thirty cases. Twenty-nine per cent fell in the seventy to eight group, while twenty-three per cent were in the eighty to ninety group so that fifty-two per cent was within normal range. The lowest pulse was forty-eight, while the highest was 132.

LABORATORY WORK—BLOOD COUNTS

Four cases had no blood work done prior to operation. Nine cases had total white counts but no differential. The total count was divided into groups as follows: 5,000 to 8,500; 8,500 to 10,000; 10,000 to 15,000; 15,000 to 20,000; over 20,000. In the 10,000 to 15,000 group forty-two per cent or 102 cases fell. The next largest group was the 5,000 to 8,500 group with forty-seven cases or nineteen per cent. There were twenty-one cases in the 8,500 to 10,000 group; forty cases in the 15,000 to 20,000 group; while there were thirty-six cases in the "over 20,000 group." The highest count was 44,000 in a ruptured appendix. All empyemas of the appendix had a count between 20,000 to 30,000. Fourteen of the early acute cases had normal white counts and differentials.

The differential counts were subdivided into those less than sixty polys; sixty to seventy; seventy to eighty; eighty to ninety; and over ninety. The largest



single group was seventy cases with poly counts between seventy and eighty, or thirty per cent. The less than sixty and the sixty to seventy group each had forty cases. There were sixty cases with poly counts eighty to ninety, and twenty-seven with poly counts over ninety. In the acute subsiding cases we noted a 9,000 to 10,000 count with an increase lymphocyte count.

URINALYSIS

These were divided into those with no pus, and those with more than ten pus cells to the high power field. There were fourteen cases in which there were more than ten cells per high power field or 5.6 per cent.

OPERATION—TYPES OF INCISION

One hundred three patients or forty-one per cent were operated through a right rectus incision. Fifty-nine patients or twenty-three per cent had a gridiron incision, while forty-four patients or eighteen per cent were operated through a McBurney incision, and only eight patients were operated through a midline incision. Thirty-five cases were not recorded.

DRAINAGE

Thirty-five cases, including the twenty ruptured cases, or fourteen per cent were drained with cigarette drains at the time of the operation. All the ruptured cases but two were drained at time of operation.

STUMP

In 132 cases the stump was inverted. In eight cases or three per cent the appendix was ligated and dropped. On forty-four per cent of the charts no mention was made of the stump disposal.

STITCHES REMOVED

These were grouped under the following days; under five days, thirteen cases; five to ten days, 193 cases or seventy-seven per cent; ten to fifteen days, eighteen cases or seven per cent; over fifteen days only one case. The least number of days was four, and the highest number of days was eighteen. Though 9.6 per cent of the histories did not have recorded the day on which the sutures were removed.

WOUND DRAINAGE

Thirty-eight cases or sixteen per cent were recorded as having some drainage from incision. These were exclusive of those cases which were drained at time of operation. Twenty cases, or 19.4 per cent of the right rectus incisions drained, six or ten per cent of the gridiron incisions, and four or nine per cent of the McBurney incisions drained.

ANESTHETIC

Forty-five cases, or eighteen per cent were operated under spinal anesthesia, and 204 cases, or eighty-

two per cent were operated under ether anesthesia.

COMPLICATIONS

Twelve cases, or five per cent had some complications: pregnancy, four cases; intestinal obstruction, one case; embolism, three cases; phlebitis, one case; auricular fibrillation, one case; and pneumonia, two cases. One of the cases was seven months pregnant and did not miscarry.

HOSPITAL DAYS

These were grouped as follows: under one week, fourteen cases; one to two weeks, 196 cases or seventy-eight per cent; two weeks to one month, thirty-seven cases or fifteen per cent; over one month three cases. The least was five days and the longest was seventy-eight days.

PATHOLOGICAL REPORT

Subacute, eighty-four cases; or thirty-four per cent; acute cases, 129 or fifty-two per cent; and under this heading we have gangrenous, two cases; empyema, nine cases; and ruptured, twenty-two cases; obliterated, twenty-one cases or nine per cent; recurrent sixteen cases or 6.2 per cent. Three of the acute cases were reported as having pin-worm ova in the lumen.

MORTALITY RATE

Out of the 250 cases there were only five deaths, giving a mortality rate in this series of two per cent. However, there were only twenty-two cases of ruptured appendices, making the mortality rate in the ruptured cases twenty-three per cent as all the deaths occurred in the ruptured cases. It is well to note that there were no deaths in the rest of the series.

DEATHS

Case 1—White, seventeen year old male, took sick six hours prior to admission with abdominal cramps, nausea, vomiting and diarrhea. On admission temperature 98², pulse ninety-two, tender over R.L.Q. with rigidity and spasticity of R. R. Urine negative, W.B.C. thirteen, 150, polys. eighty-nine per cent, was operated through R.R. incision, under ether anaesthetic. Stump inverted, two cigarette drains inserted—200 cc. Colibactrogen intra-abdominally. Fourth P. O. day first drain removed, seventh P. O. day second drain out. Patient expired suddenly twelfth P. O. day at 12:15 p.m. with diagnosis of pulmonary embolism.

Case 2—White, fifty-four year old female, took sick about twenty-four hours prior to admission with history of generalized abdominal pain, with nausea and vomiting, bowels negative, no laxative. On admission temperature 108⁸, pulse eighty. Physical examination essentially negative except for tenderness over McBurney's point and some rigidity and spasticity of R.R. No vaginal made. Urine negative,

W.B.C. 19,000, polys. eighty-five per cent. Patient operated under ether anaesthesia. R.R. incision, appendix ruptured and gangrenous removed, stump partially buried, one cigarette drain, neo-prontosil I. M., drain removed seventh P. O. day, stitches out eighth day. Patient expired suddenly at 8:30 p.m. on twenty-ninth P. O. day with diagnosis of pulmonary embolism.

Case 3—White, fifty-seven year old male, history of sudden onset of diffuse abdominal pain, nausea and vomiting, took argarol. On admission, eighteen hours after onset, temperature 102⁴, pulse 104, respiration thirty, physical-essentially negative except for generalized abdominal rigidity, W.B.C. 8,300, polys. eighty-five per cent, urine, trace albumin. Patient operated under spinal anaesthetic through R. R. incision. Appendix not removed, three cigarette drains, neo-prontosil orally, on fourth P. O. day developed auricular fibrillation, was given digitalis, died suddenly on ninth P. O. day with diagnosis of embolism.

Case 4—White, fifty-four year old female, history of sudden onset of generalized abdominal pain which in twelve hours localized in R.L.Q. and was treated by osteopath for seven days. Admitted with generalized abdominal pain, rigidity and distension. No vomiting, nausea or diarrhea. Physical examination

essentially negative except for diffuse board-like rigidity. Vaginal examination negative except for pain on motion of cervix. Rectal negative, urine negative except for acetone, W.B.C. 12,250, polys. eighty-eight per cent. Patient operated under spinal anaesthetic, through McBurney incision, appendix not removed, two cigarette drains, no sulfa-drugs. Died on eleventh P. O. day of toxemia, and generalized peritonitis.

Case 5—White, forty year old male with sudden onset of epigastric pain twelve hours prior to admission, constipated with nausea and vomiting. On admission temperature ninety-eight, pulse sixty-two, respiration twenty. Physical examination essentially negative except for cyanosis of lips, and board-like rigidity of entire abdomen. Urine negative except for hyaline casts and trace of albumin, W.B.C. 14,400 polys. seventy-nine per cent. Operated under spinal anaesthetic, through R.R. incision, abdomen filled with pus, appendix not removed, three cigarette drains, neo-prontosil I. M., died on fifth P. O. day of generalized peritonitis and toxemia.

CONCLUSIONS

(1) The writer feels that this report is of particular importance because it reviews the cases of appendicitis of a small general hospital, covers the

ACUTE APPENDIX—RUPTURED—RECOVERED

Age	Sex	Duration	Treatment	Type of Incision	Anaesthetic	Sulfa-drugs	Hosp. Days	Complications
12	M	3 days	Appendix out	McB	Ether		18th	
14	M	3 days	Appendix out	Grid	Ether		29th	
20	M	12 hours	Appendix out	R.R.	Ether		15th	
21	M	7 days	Drained only	Grid	Ether		22nd	
27	M	7 days	Drained only	?	Ether		18th	
41	F	7 days	Drained only	R.R.	Ether		24th	
51	F	14 days	Appendix out	Mid	Spinal		54th	
53	F	10 days	Drained only	Grid	Ether		78th	Phlebitis
67	M	6 hours	Drained only	R.R.	Ether		40th	
67	M	6 days	Not operated				11th	
11	M	4 days	Appendix out	?	Ether	Sulfathiazole orally	29th	
14	F	42 hours	Drained only	R.R.	Ether	Neo-P I.M.	21st	
40	M	24 hours	Appendix out	?	Ether	Sulfathiazole orally	16th	
4	F	6 days	Drained only	R.R.	Ether	5 gms. Sulfanilamide in wound + drain	44th	Lung Abscess
8	M	48 hours	Appendix out	R.R.	Ether	Sulfanilamide in wound + no drain	12th	
15	M	18 hours	Appendix out	McB	Spinal	Sulfathiazole in wound no drain	12th	
29	F	24 hours	Appendix out	R.R.	Ether	Sulfathiazole in wound no drain	14th	

ACUTE APPENDIX—RUPTURED—DIED

17	M	6 hours	Appendix out	R.R.	Ether	Coli Bacterogen in wound	12th	Embolism
40	M	12 hours	Drained only	R.R.	Spinal	Neo-P I.M.	5th	
54	F	24	Appendix out	R.R.	Ether	Neo-P I.M.	29th	Embolism
54	F	7 days	Drained only	McB	Spinal		11th	
57	M	18 hours	Drained only	R.R.	Spinal	Neo-P orally	9th	Embolism

years just previous to the use of the sulfonamide compounds and gives a brief comparison with cases treated later with the sulfonamide group of drugs.

(2) The mortality rate for the entire group is two per cent, the rate for perforation with peritonitis is twenty-three per cent. This rate compares favorably with reviews from other hospitals.

(3) It is interesting to note that in the group in which the sulfonamide drugs were used the morbidity was markedly reduced.

(4) Eighty per cent of the cases which died were operated within twenty-four hours from onset.

(5) In the five deaths that occurred the appendix was removed in forty per cent of the cases and only drained in sixty per cent of the cases, while in those cases which had a perforation and recovered fifty-six per cent had the appendix removed while forty-four per cent were drained only.

(6) Although this series is small, nevertheless, it does indicate the trend in the proper treatment of these patients.

Tyrothricin, a bactericidal substance recently isolated from a soil bacterium, applied to ulcers resulted in sterilization and healing if the local infection was caused by *Streptococcus haemolyticus*, *Staphylococcus aureus* or *Streptococcus faecalis* and encouraging results were obtained when it was applied to mastoid cavities following mastoid operations, Charles H. Rammekamp, M.D., Boston, reports in the current issue of "War Medicine." The latter is published bimonthly by the American Medical Association in cooperation with the Division of Medical Sciences of the National Research Council.

Dr. Rammekamp's findings are based on the use of the substance in the treatment of fifty-eight localized infections, most of them located on the arms or legs of patients, and its application at the time of operation to fifteen mastoid vacities infected with hemolytic streptococci.

"Early in the present studies," Dr. Rammekamp says, "it was noted that in an infection associated with a mixed flora, that is, both with gram-negative and with gram-positive organisms, it was impossible to rid a lesion of the gram-positive component, even though large amounts of the bactericidal substance were applied. . . ."

He says that the results obtained in the mastoid group justify further trial of the substance in the treatment of mastoiditis following operation.

"The value of tyrothricin in the treatment of other forms of infection has not been established," Dr. Rammekamp says. "Superficial streptococcal infections of wounds, burns or skin should respond to the local application of the bactericidal substance; staphylococcal infections are likely to be much more resistant. . . ."

He says that inasmuch as gramicidin, a substance obtained from tyrothricin, has been shown to be less toxic and at the same time more potent against gram-positive organisms, "it appears likely that this substance may prove more useful in the treatment of certain localized infections."

THE RELATION OF THE RADIOLOGIST TO THE HOSPITAL

C. H. Warfield, Lt. Comdr., U. S. Navy, M.C.

Wichita, Kansas

This subject will be discussed in two phases, namely the relation of the hospital to the radiologist and the radiologist to the hospital.

Neither the first or second part of this subject has received discussion by either party until the last ten years or so. This has been brought about primarily by the change in our present national economic set up which has resulted in the loss of large endowments and in many cases the inability of Mr. and Mrs. Jones to pay promptly or at all. In seeking a new source of revenue, the idea of some form of insurance seemed to be the ideal answer. If insurance was to be made attractive to the prospective buyer it would have to carry as much coverage as possible in order to be saleable and attractive. When a hospitalization insurance policy is purchased the buyers certainly looks for one that pays all his accounts when sick or injured. This is his ideal.

We may as well speak very frankly at this point, that any form of hospitalization insurance which guarantees the beneficiary complete coverage of his hospital statement will no doubt meet opposition by the medical profession. Many hospitals are making profits by this scheme, violating the code of ethics of the American Medical Association and are engaged in the practice of medicine.

As to the hospital they would be satisfied since all bills contracted would be paid and there would be no use for an expensive collection system with the subsequent loss of fifteen to twenty per cent of the accounts annually, to say nothing of good will. We all know too well how patients get so perturbed when it comes to paying on time or at all. It would be possible with insurance coverage to make an adjustment for the loss of revenue and be on the black side of the ledger. Of course this can only be accomplished where the administrator is well trained, experienced and honest.

HISTORY OF THE HOSPITAL

Let us analyze briefly the hospital during the last several decades if possible to see if there is not a basic reason for changing what has gone on peacefully before.

The earliest hospitals were usually conceived, promoted and operated by doctors and the church.

As soon as modern scientific methods became necessary and the great increase of hospitalization began, the financial burden was such that church

organizations as a whole, schools and outside agencies began to construct, equip and maintain hospitals. Since this involved large sums of money it was logical that the hospital would seek the aid of successful business men. They could not only use their money and good will but their successful business principles in building up this new organization structure. Quite naturally these business men turned to the corporate structure for organization.

The result was that the hospital, which had only been a private institution became in a short time an impersonal organization, operated on business lines, enclosed in the legal shell of a corporate charter and administered by a board of trustees composed almost entirely of laymen.

This corporation then hired nurses, orderlies, technicians and interns to carry out the instructions of the attending physicians. As scientific medicine progressed they bought expensive equipment. Included in this was x-ray and radium equipment. This started about 1900. In many cases this scientific equipment, especially x-ray machines was purchased after the money had been obtained by the death of some benevolent individual. Being paid for in cash a short time after installing there is no interest or carrying charge to pay. The only expense being maintenance. This is in contrast to the radiologist who pays for his equipment as it grows older and more antique through the profit that he can realize.

Since this scientific machinery was highly specialized a physician had to be called in to interpret shadows on the films in terms of pathology and keep the equipment in good running order. Logically the hospital would pay for these service since money was being charged for these x-ray examinations. This then brings to light the fact that the corporation is employing a man of one of the learned professions.

RADIOLOGIST AND THE HOSPITAL

At this point let us diverge a moment and analyze briefly the types of fiscal arrangements existing between radiologists and hospitals. Among radiologists practicing their specialty in hospitals in this country, 36.4 per cent are on a straight salary basis. Another 7.3 per cent are paid a salary by the hospital plus a percentage of the gross collections or net profits. The great majority of radiologists serve in the hospitals on a commission basis, 47.3 per cent receiving as compensation a percentage of the gross or net income. About nine per cent of the radiologists practicing in the hospitals lease the roentgen department, paying the hospital a monthly rental therefor.

The latter method is one approved by the American College of Radiology because his practice is the same as if he were in an office building, and is treated with the same consideration as other mem-

bers of the staff. All fees charged by the radiologist shall be directly under his control and all systems of rebates and discounts shall be considered unethical unless waived or adjusted by him.

The percentage agreement can be made ethical. It should be applied to the gross receipts of the department and not the net, as this would give prime facie evidence that the hospital was enjoying a profit from the professional services rendered. In the great majority of institutions the hospital cost should be defrayed with fifty per cent of the gross receipts or less.

We may then ask the question, is the practice of medicine by corporations unlawful?

Practically all states in the Union have enacted laws prohibiting the practice of medicine by corporations. Similar statutes prevail prohibiting the corporate practice of law, dentistry and other learned professions. These laws have been passed for the simple reason that the practice of the learned professions by artificial legal entities would not be to the best interests or welfare of the people. Hospitals are artificial legal entities and it is hard to understand why the same reasoning should not be applied in their case. The public would surely suffer as the result of this kind of corporate practice the same as it would in the case of non hospital corporations. The type of organization is relatively immaterial. In any case the traditional and indispensable personal relationship between a doctor and his patient will be destroyed or injured under such conditions.

A hospital which employs a physician on a salary or other stipulated compensation, the hospital charging and collecting fees for the physicians services, is according to general authority itself engaged in the practice of medicine.

It has been stated rather loosely and with wishful expression that a hospital is not a corporation and is not practicing medicine. A corporation is a creature of the law that can operate only through the principles of agency. Being an artificial legal entity, it cannot act itself, but only through others. If the physician is regarded as an agent of the corporation employing him, his acts are the acts of the corporation and the corporation is regarded as practicing medicine. In the case of Mallory vs. White the United States District Court of Massachusetts held that if the hospital employs the physician he is an agent of the hospital and therefore not an independent contractor. This also places the physician under the workmans compensation for an injury arising out of and in the course of his employment.

The hospital then seeks to turn to the fact that it is a type of corporation which because it is non-profit the laws applicable to profit corporations do not apply. Even then that is no defense against the

fact that they are not practicing medicine. The law in this state does not qualify the word corporation nor does it exempt hospitals. The hospital probably can show at the end of the year that no profits have been made in the institution as a whole. However, no one can convince the radiologist that fees earned by him are not being used to defray expenses in another department of the hospital. Hospitals have been known to make \$75,000.00 per year from the x-ray department but could not pay more than \$5,000.00 to the radiologist. This is exploiting the knowledge, training and experience of a professional man working many times under the veil of a church name and sponsorship. Administrators must show a good report to the lay board of trustees at each monthly or yearly meeting in order to justify their salary or requests.

We as physicians must not lose mind of the fact that we must live up to a certain code of ethics partly because we are making a living from the unfortunate happenings of life itself. Thus the American Medical Association has approved a code of ethics which applies to the case under discussion. It is as follows: It is unprofessional for a physician to dispose of his professional attainments or services to any lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit a direct profit from the fees, salary or compensation received to accrue to the lay body or individual employing him. Such a procedure is beneath the dignity of professional practice, is unfair competition, with the profession at large, is harmful alike to the profession of medicine and the welfare of the people, and is against sound public policy. For further facts and proof of these statements I refer you to several articles recently published in the American Journal of Roentgenology and Radium Therapy, and Radiology written for the intersociety committee by Mac F. Cahal, executive secretary.

Let us now discuss some points relative to the radiologist and the hospital which if followed will be more of an asset to the hospital than to the individual concerned.

The method of obtaining a radiologist is the first consideration. The Chicago Roentgen Society considers it unethical for one radiologist to try and convince a hospital administrator that he is a better man than the one employed and try to undermine him in favor of himself. The hospital staff should with the advice of the board and the administrator discharge the present man and then proceed to locate a new man.

EMPLOYING A RADIOLOGIST

The method of obtaining a new radiologist should be done by having the chief of staff appoint a phy-

sician committee to interview and study the credentials of the man. They must be satisfied that he has training and experience which will meet requirements that they should set up. His morals, honesty, loyalty, fitness, judgment, discretion and ability to get along with others are equally as important. Friction between members of the staff can be very annoying. Under no circumstance should the board of trustees employ the man direct without consulting the staff. The only part that they play is to meet the prospect selected by the staff and make the necessary formal arrangements to bring him to the institution.

HOSPITAL EQUIPMENT

The second most common mistake is that the institution discovers that their x-ray equipment has become antiquated and does not satisfy their present needs. Many times the salesman for the companies dealing in x-ray equipment interviews and deals exclusively with the administrator and members of the board. The reason being that the radiologist may not like the salesman or even the type of equipment that his company makes. In fact the radiologist may know the history of the company as well as the traits of the salesman, either of which may be objectionable. A good radiologist should know best what type of equipment is best suited for his use as well as what make of apparatus he prefers to use. Friction between the radiologist and a salesman can be most distracting for an administrator.

Another not infrequent method is to purchase the equipment, again being at the mercy of a salesman who knows that a certain amount of money is available, then employ the radiologist. Somewhat along these lines the hospital board designates a certain room or rooms in which to install the equipment and no more is available. This not infrequently results in the fact that the machinery is cramped into too small quarters or the arrangement of the rooms has not been altered to accommodate the machinery. Many times no provision is made for viewing and film storage as well as consultation rooms. A small inadequate, poorly lighted, poorly ventilated processing room may defeat the desired results seventy-five per cent.

The perfect location of the x-ray department in relation to other existing departments and the relation to each other can not be discussed in this short paper. In passing I must admit that no hard and fast rules exist and even several radiologists may disagree on its location.

The radiologist can be of invaluable service to the department of nursing. He should make his education and experience available to help in the visual demonstration of anatomy and physiology to the first year students. He can show anatomical parts of

the body on films so that the nurses class room work will be made easier. The actual beating of the heart, respiration, swallowing and movement of food through the intestines can be shown. In the subject of practical nursing he can augment the instructors work. For example he can actually show what happens when the patient is given an enema. At this point he can give the nurse some very practical points relative to technic which he finds to be very helpful. The nurse should be asked to assist in the x-ray department with the handling of patients so as to familiarize herself with what is required of patients in the line of cooperation. In doing this she may be of great assistance to the referring physician when he asks her if she thinks the patient too weak to be taken to the x-ray department.

The radiologist should teach the nursing staff the procedure to follow when patients must receive certain types of preparation before x-rays are taken. The radiologist will experience more cooperation from the nurses if he will take the time to explain why a certain procedure must be followed in order to obtain the best x-ray films. For example she should know why a patient should receive no breakfast the morning he is to have his gall bladder examined or why he should have no water to drink twelve hours before certain kidney examinations.

The radiologist should also assist in the examination of all new nurses by studying the lungs and heart for disease. This may be invaluable in keeping sick help out of the hospital, as such may not only be a menace to patients as well as a liability to the hospital.

He should welcome constructive criticism from the administrator so as to better the attitudes between all people connected with the institution. He should be on the alert to observe complaints from patients regardless of who may be at fault.

Since the radiologist is in the hospital the major portion of the working day he should be of assistance in many ways to the superintendent of nurses and the administrator. A friendly attitude between these three people can be a great asset to the institution.

In conclusion altho some statements may have been made to which one could take offense, I am sure that these facts have been known for some time. I wish to make it clear that in no case have I singled out any one institution just to make it an example before the others.

NOTE—Mr. Mac F. Cahal, executive secretary of the American College of Radiology has furnished much of the material in this presentation.

TREATMENT OF NAIL PUNCTURE WOUNDS OF THE FEET

Maurice A. Walker, M.D.

Kansas City, Kansas

Patients who have stepped on nails ordinarily come to the physician within a few hours. Some are seen one or two days after the injury, however, usually having spent a good deal of the intervening time soaking the foot in warm water. The swelling of the damaged tissues is aggravated by this heat and dependency and, since the tough plantar callus allows little room for expansion, pain is increased and visible lymphangitis on the dorsum of the foot frequently develops. The patient then concludes that he needs medical attention.

The following treatment of nail puncture wounds of the feet has been used in 220 cases since 1937, about equally divided between private practice and one large industry. None of the patients seen within twenty-four hours of injury has lost time from work except for the remainder of the shift on which he was working. No infections of consequence and no cases of tetanus have developed.

The patient is laid flat on a table with the foot elevated on a small pillow or block. This position makes it easier for the physician to work and decreases bleeding that might occur. Rubbing alcohol is swabbed over the wound which is usually sealed and looks insignificant. Using a double-edged razor blade flexed between the thumb and fingers to make a curved cutting edge, a circular patch of plantar callus about one inch in diameter is removed, leaving thin pink skin around the nail hole. At this depth there is a jagged opening containing bloody watery fluid and often dirt, sand, or rust depending upon the condition and environment of the nail. The remaining irregular edges of this wound can be trimmed with the razor blade or with cuticle scissors. It has thus been converted from a sealed pocket covered by a plate of unyielding callus to an open wound surrounded by an area of soft thin skin. Debris may be picked out of the wound with small forceps, or washed out with soap and water or peroxide, using pledgets of cotton. Alcohol is again applied and the wound protected by a small dry dressing. The patient is advised to remove this dressing before going to work next day, by which time the wound is usually dry and almost healed and needs no further protection. Antitetanic serum is administered to all patients with nail puncture wounds.

If the patient is seen soon after the injury he is

(Continued on Page 456)

President's Page

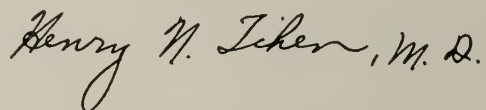
To the Members of The Kansas Medical Society:

In the busy life of the doctor there is usually all too little time devoted to an understanding of the social and legislative forces which control our destiny far more than we often realize and yet unless we study and understand these forces both in the State and in the National Governments, we will have but little influence in guiding the destiny of medical practice.

The National Physicians Committee (N.P.C.) and its activities have been approved by the House of Delegates of the American Medical Association at its last meeting in Atlantic City. Because of legal restrictions, the guidance and protection of the legislative interests in Washington of the medical profession and of the public as regards medical problems cannot be undertaken by the American Medical Association. This fact has been definitely settled by the American Medical Association itself and therefore the medical profession must have an organization to represent it before the people and in the halls of Congress. This is the function undertaken by the National Physicians Committee and therefore I am asking the doctors of Kansas to give their moral and financial support to this Committee and its activities. We must have such an organization if the medical profession is to have any influence whatsoever in the guidance of medical development in this country.

In the interests not only of the profession, but of the public medical welfare, we must support the National Physicians Committee in an effort to continue the ever-upward course of medical progress. In a subsequent issue of the President's Page I will discuss some methods by which the National Physicians Committee can further increase its effectiveness.

Sincerely,

A handwritten signature in cursive script that reads "Henry M. Tihen, M.D." The signature is fluid and elegant, with the first name "Henry" being the most prominent.

President, The Kansas Medical Society.

EDITORIAL

RECENT TRENDS

The Procurement and Assignment Service for Physicians, Dentists and Veterinarians in spite of a slow start, seemingly contradictory instructions and a delay in adopting a state quota system has done a good job in providing the Army with doctors. This is evidenced by the fact that the great majority of state recruiting boards were withdrawn last month, their quotas having been met in these states. It is rather definitely understood that no further quotas will be assigned until all laggard states have provided a full 100 per cent.

At the same time the state procurement and assignment committees have endeavored to retain a sufficient number of physicians to man the home front adequately for real needs. In certain localities, due to circumstances often beyond their control such as shifts in population and early volunteering of essential men, inequalities in the distribution of medical care have developed altho they are small in the whole picture. The Procurement and Assignment Service has approached the problem of meeting the needs of the armed forces, industry and the civilian population in a scientific manner with complete files of physicians and the necessary machinery to protect the public health.

In spite of this work Senator Claude Pepper recently released a report to the public from his subcommittee on Man Power which contains the following statement:

"It is the committee's opinion that an over-all civilian authority should be established at once to supervise and control the drafting and recruiting of doctors. Until this authority is actively functioning, no recruiting of doctors for the armed services should be permitted."

A recent article by Dr. Thomas Parran in *This Week* advances the theory that some federal agency should be empowered to redistribute the remaining portion of the medical profession:

"As a first step toward making the most of what we shall have left when the armed forces have been supplied with doctors and nurses, it would seem advisable for the War Manpower Commission to ration medical manpower just as the Office of Price Administration rations other essentials of civilian life; so that everybody may have something instead of some people having nothing."

Following this an article appears in the November, 1942, *Harpers* by Michael M. Davis, the former di-

rector of medical services for the Rosenwald Fund which states.

"The need and the machinery for action have both been demonstrated. Under Surgeon General Thomas Parran the United States Public Health Service has found out the medical, sanitary, and hospital needs of war areas by first-hand field studies. Let us hope that, by the time this article is in print, the Public Health Service will have been given the long-delayed authority to act as well as study. Should governmental timidity permit a division of responsibility between the Public Health Service and the Procurement and Assignment Agency—a compromise toward which at this writing official medical pressures are exerted—the settlement will be only temporary because it will certainly be ineffective in handling the problem."

Apparently a determined effort is being made to regiment the physicians of the United States, prior to the passage of any new Man Power Act by Congress, in a condition of involuntary servitude. No constructive suggestion has so far emanated from these political and extraneous sources. It is to be hoped that conferences being held in Washington with all interested agencies will reach a sane solution of these present problems.

DR. CRUMBINE OF KANSAS

Dr. Samuel J. Crumbine, formerly Secretary of the Kansas State Board of Health, was the guest of honor of the Kansas Society in New York at a dinner on November 12 at the Waldorf-Astoria Hotel. The dinner was given in honor of the thirty-fifth anniversary of the abolition of the public disease-spreading drinking cup, credit for which goes to Dr. Crumbine. Dr. Crumbine, who is now retired at the age of eighty years, is living in Jackson Heights, New York.

Dr. Crumbine was a practitioner in Dodge City and a member of the Kansas State Board of Health when he was appointed to the position of secretary of the board in 1904. Kansas has to her credit many pioneers and in Dr. Crumbine has added a pioneer in the field of medicine. Although he is best known for his campaign to abolish the common drinking-cup, his "swat the flay" campaign and the abolishment of the roller-towel were also of great health importance. In 1905 he collected the first samples of food and drugs brought to the laboratories of the University of Kansas for analysis and two years later advocated the passage of the first state food and drug inspection laws. He was the instigator of the laws of the state regulating water and sewage. In 1909 he advocated the bill to make tuberculosis case reporting mandatory. In 1911 he promoted the passage of the

vital statistics law, which due to the activities of the war, and the old age pension act has become of such great importance. He extended the Division of Communicable Disease of the state and in 1915 created the Division of Child Hygiene.

In 1923 he resigned as Secretary to the State Board and was appointed by President Herbert Hoover as executive of the American Child Health Association. Kansas is very proud of Dr. Samuel J. Crumline's efforts in pioneering in the field of health.

ARTHUR D. GRAY

Arthur Gray whose obituary appears on another page of this Journal was an outstanding member of the medical profession in Kansas. While not particularly active in the affairs of the State Society he exerted a wide influence on the application of the Public Health Services' campaign against venereal disease in Kansas and acted as their consultant in this work. For years he was the head of a clinic for the treatment of such cases which pioneered Dr. Parrans' program in this part of the state. Dr. Gray's work in diagnostic urology was outstanding, especially so since he was the first specialist in his field in Topeka.

Aside from professional accomplishments he had a rare capacity for friendship and a great creative artistic ability which manifested itself in the showing of puppets, writing plays, shipbuilding and photography. His warm personality and professional skill have made a great contribution to medical life in Kansas in the past thirty years.

TUBERCULOSIS SEAL SALE

The Kansas Tuberculosis seal sale with a goal of \$75,000 begins officially on November 23. Last year's sale netted \$68,039.83 and it is believed that this year's sale will go well over the estimated quota.

The 1942 Christmas seal was designed by the artist Dale Nichols and portrays a farm snow scene with a red barn in the distance and an old-fashioned swell-front sleigh in the foreground. The seal is unusually attractive and with the people of the United States in a stamp and bond frame of mind should sell in large quantities.

This year's slogan "Protect Your Home from Tuberculosis" is noteworthy due to the reports that fifteen per cent more tuberculosis is being reported in England than before the war and that all war participating countries have had a notable increase in the disease.

Buy your Tuberculosis Christmas Seals early and in your own town as active representatives in each county hope to make the 1942 campaign an outstanding one.

THANKSGIVING 1942

The Journal of The Kansas Medical Society sends greetings for a happy Thanksgiving to all of its readers, both those at home and those in the service of their country located at some un-named post of duty.

It is believed that Kansas doctors of medicine are serving in almost every place in which the United States Army, Navy and Air Forces are stationed. The sacrifice these men and their families are making is indeed great and worthy of a greater Thanksgiving when victory is at last ours.

TREATMENT OF NAIL PUNCTURE WOUNDS OF THE FEET

(Continued from Page 453)

directed to cease work for the remainder of the day. In all cases, after treating the wound as just described, he is strictly instructed to elevate his leg on two or three pillows, well above his body. This position is to be maintained for twelve hours and repeated for twenty-minute periods every four hours during the next few days if there should be any swelling or pain. He is warned particularly against the time honored but harmful custom of soaking the injured foot in hot water.

The United States Civil Service Commission recently issued a call for public health nurses. The positions pay \$2,000 a year and the requirements are: completion, subsequent to January 1, 1920, of a full course in a recognized school of nursing including two years in a general hospital having a daily average of fifty bed patients or more; registration as a graduate nurse; and completion of one year of study in public health nursing at a college giving a course of study approved by the National Organization for Public Health Nursing. One year of public health nursing experience is also necessary.

Other nursing opportunities open in the Federal service include the following: Junior Public Health Nurse, \$1,800 a year; Graduate Nurse, \$1,800 a year; Junior Graduate Nurse, \$1,620; Graduate Nurse for the Panama Canal service, \$168.75 a month; Nursing Education Consultant, \$2,600 to \$4,600 a year; and Public Health Nursing Consultant, \$2,600 to \$5,600 a year. Except for Panama Canal service there are no age limits for any of these position. Applications will be accepted at the Commission's Washington office until the needs of the service have been met.

NEWS NOTES

RECRUITING BOARD WITHDRAWN FROM KANSAS

On October 26 the office of the Medical Recruiting Board for Kansas, located at 215-17 Postoffice Building in Topeka were relieved by order of the Commanding General of the Headquarters of the Seventh Service Command of Omaha, Nebraska.

The office which was installed on May 18 for the purpose of receiving applications for commission from the medical, dental and veterinarian profession, had during its tenure received 307 applications from doctors of medicine in the state. This figure includes only those who applied for commission through the Board and did not include commissions granted through other sources. Major H. J. Dixon and Major R. W. VanDeventer were in charge of the work of the Board.

The following information was released by the Board, which it is believed will be of interest to members:

SUMMARY OF BOARD ACTIVITIES

Number of Physicians appointed by the Board.....	102
Number of Physicians rejected.....	67
Applications forwarded to Surgeon General's Office for final action	60
	229
Applications on file—at present Not Available—forwarded to the Surgeon, Seventh Service Command, SOS, Omaha, Nebraska, at closing of office.....	69
Applications on file—Available	9
	307

Physicians under age forty-six (46) who have not applied for commission in the Armed Forces (a large majority of this group is classified as not available for military duty at the present time)..... 63

Major Dixon on leaving the office directed the following to the profession:

"The members of the Board desire to thank all physicians in the state who have cooperated in any and every way to make our stay in the state both pleasant and productive of results, considering the mission of recruitment of physicians for the Army. We leave the state with pleasant memories of our association with you and we expect to rub elbows in the future with some of you whom we have assisted in securing commissions in the Medical Corps of the Army of the United States."

Major Dixon also informs us that he was recently in receipt of information from the office of Surgeon General at Washington that doctors who have reached the age of forty-five but have not yet had their forty-sixth birthday may be commissioned as Captains. This information is of great interest in that the subject has been a controversial one.

PORTER LECTURES

The University of Kansas School of Medicine announces that the twelfth Porter Lecture will be given by Dr. Irvine McQuarrie of Minneapolis, Minnesota. Dr. McQuarrie is a Professor of Pediatrics of the University of

Minnesota Medical School of Minneapolis and of the University of Minnesota Graduate School of Minneapolis and Rochester.

The schedule of lectures are as follows:

Tuesday, November 3—8:00 p.m. Kansas City—"Experiments of Nature and the Advancement of Medical Knowledge".

Wednesday, November 4—10:30 a.m. Lawrence—"Medical Experiences in Besieged China".

Wednesday, November 4—8:00 p.m. Kansas City—"Diseases of Adrenal Glands in Children".

The funds for the Porter Lectures were given to the University of Kansas in 1918 by Dr. J. L. Porter of Paola, who desired to stimulate research and scholarships at the Medical School. A part of the income from the bequest is used for scholarships for worthy students and the remainder for the expenses of the annual lecturer on medical subjects.

The University of Kansas School of Medicine sends a cordial invitation to all interested students and physicians to attend the lectures.

NEW STATE OPHTHALMOLOGIST

Dr. W. W. Reed of Topeka was appointed on November 1 as State Supervising Ophthalmologist to the Kansas State Board of Social Welfare. Dr. Reed succeeded Dr. H. L. Kirkpatrick also of Topeka who recently resigned to accept a commission as Captain in the Medical Corps of the United States Air Service.

SURGICAL CARE, INC.

The Jackson County Medical Society Weekly Bulletin for November 14 and the November 5 issue of the Kansas City Star announce the advent of the new pre-payment care plan for surgical cases which is limited to persons of moderate means. The plan which is called Surgical Care, Inc., is controlled by doctors of medicine, is not-for-profit and chartered under the state of Missouri.

The plan which has been studied since 1938 by three committees and finally approved by the Jackson County Medical Society has the following officers: President, Dr. Ira H. Lockwood; Vice-President, Dr. Frank D. Dickson; Treasurer, Dr. W. M. Ketcham, and Secretary, Dr. Frank L. Feierabend.

All duly licensed doctors of medicine are eligible to apply for membership. Those who participate are paid directly from the plan and do not accept remunerations from the patient members for any services in the category of surgery, obstetrics and orthopedics. Anesthesia is included in the benefits when administered by a physician, though all diagnosis and medical services are excluded, the exception being x-ray in connection with accidental injury.

The plan is for those persons in the moderate income groups; a single person to be eligible must earn annually not more than 1,800.00, a married person (husband and wife) not more than \$2,400.00, with a full family, including all children under eighteen years of age not more than \$2,600.00 (with one child), \$2,800.00 (with two children) and \$3,000.00 (with three children).

The physicians participating are spared the red tape and paper work. The object of the plan is to bring complete surgical, obstetrical and orthopedic care to all persons in the average and lower income groups on a modest monthly pre-payment basis. A similar plan is now in op-

eration in Michigan, New Jersey, Pennsylvania, and Colorado, with plans in the western area of New York state and Buffalo, New York. The Michigan Medical Service Corporation has 487,000 members in its organization.

ANNOUNCEMENTS FROM SURGEON GENERAL

The Editorial Board has received the following communication from Thomas Parran, Surgeon General of the United States Public Health Service:

"Since the passage of the Venereal Disease Control Act in 1938, the importance of the pharmacist as a factor in the control of the venereal diseases has achieved increasing recognition. This is to be expected because the pharmacist is usually the first to be consulted by those who have, or suspect they have, a venereal disease.

"The pharmacist himself is more aware than anyone else of his responsibility to the community in assisting the health authorities in this most urgent task of bringing venereal patients under proper treatment. Through his professional organizations, notably the American Pharmaceutical Association, and with the cooperation of the American Social Hygiene Association, the pharmacist has demonstrated an active willingness to participate in the national program for control of syphilis and gonorrhea.

"Today, the need for protecting the Nation's manpower from venereal infections calls for redoubling the efforts of all forces engaged in this vital public health problem. For this reason, the United States Public Health Service has prepared a statement clarifying the role of the pharmacist from the public health viewpoint in the control of venereal diseases, and to reemphasize his importance in the community as an educator, a personal influence, and a citizen."

Surgeon General Parran recently announced that Dr. Udo J. Wile, formerly Professor of Dermatology and Syphilology of the School of Medicine of the University

of Michigan, has been commissioned Medical Director in the United States Public Health Service for active duty with the Division of Venereal Disease Control. Dr. Wile will supervise the quarantine hospitals which are being developed in a number of the critical war areas for the treatment of prostitutes and recalcitrant persons who are infected with syphilis and who are capable of spreading the disease. These hospitals are under the supervision of the Public Health Service and the various states in which they will be located.

RECRUITING PHYSICIANS

The Office of War Information of the War Manpower Commission recently released the following information:

"The Directing Board of the Procurement and Assignment Service is pleased to announce that ninety-five per cent of the 1942 procurement objective of medical officers for the armed forces has already been met. Toward this total a number of states have supplied more than their share of physicians and only a few states are lagging behind in their quotas. It is from these states that the additional physicians needed during the current year should come.

"The recruitment of such a large number of physicians in a few months is a remarkable achievement and another demonstration of the traditional patriotism and unselfishness of the medical profession. In this achievement, and particularly in those of its members who are "in service", the profession can justifiably take pride.

"The end, of course, is not yet. Increases in the armed forces will necessitate more medical officers and additional demands will be made upon the profession for medical services in critical war production areas. The Directing Board is convinced, however, that the physicians of this country will respond to future calls for service, whatever

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they may be, in the same splendid manner with which they have already volunteered for service with the armed forces."

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Harold S. Diehl, M.D.
Harvey B. Stone, M.D.
James E. Paullin, M.D.
C. Willard Camalier, D.D.S.
of the Directing Board

CHIEF OF GASOLINE RATIONING APPEALS TO PHYSICIANS OF U.S.

An open letter to all physicians of the United States from the chief of the Gasoline Rationing Branch, Office of Price Administration, concerning the vital role they will play in the rationing of gasoline and tires, is published in the Medicine and the War section of The Journal of the American Medical Association for October 31. The letter is as follows:

"In the East Coast Gasoline Rationing program, made necessary by the shortage of transportation facilities for petroleum products, the indispensability of your profession was recognized by its inclusion in the categories of persons eligible for preferred mileage, that is, necessary occupational mileage in excess of 470 miles a month. Now the Office of Price Administration has been ordered by Mr. William Jeffers to institute and administer a nationwide mileage rationing program for the express purpose of conserving our rubber-borne transportation. In framing the Regulations for the new program, your profession was one of the first to be provided for.

"If we are to carry out our double task of preventing a collapse of our military and civilian transportation, we must have the complete cooperation of those groups of persons whose driving is deemed essential to the war effort. Our immediate aim is to attain the 5,000 mile national mileage average set by the Baruch Report as the maximum possible in light of the dire rubber shortage.

Our experience with the East Coast program tells us that the preferred categories use one-half of the gasoline consumed, though they constitute less than one-fourth of the total number of automobile operators. Clearly, then, the great savings of rubber on a nation-wide scale must be made in the preferred categories.

"Under the Regulations, governing the mileage rationing program, physicians are eligible for preferred mileage if their essential occupational needs exceed 470 miles a month and if the mileage is needed for regularly rendering necessary professional services. Mileage traveled daily or periodically between home or lodging and a fixed place of work is not considered preferred. Physicians who conduct their practices in offices, as many specialists do, are not eligible for preferred mileage.

"Without question or hesitation, doctors have been and will be granted all the gasoline needed to carry out their professional work. We hope that they will regard their concrete symbol of their indispensability, the C book, as a moral obligation and not as a personal privilege. From another point of view, the C book is part of a doctor's equipment; it should not be used for anything but the work of humanity.

"When nationwide gasoline rationing begins, there are certain concrete things a doctor can do to live up to the high ethical standards set for him by his own profession:

"1. At the time of first issuance of rations, he can so carefully compute his necessary mileage as to make a B book adequate for his purposes though he might easily make out a case for a C book, which might be granted to him without question by his local War Price and Rationing Board eager to provide for physicians.

"2. In the computation of his mileage, he can religiously adhere to the provision of the Regulations, which makes 150 miles of his basic ration available for occupational purposes. Moreover, he can help mightily in establishing the principles that only 90 miles of the basic ration are to be used for home necessary use and that there is no provision whatever in any ration for 'pleasure driving.'

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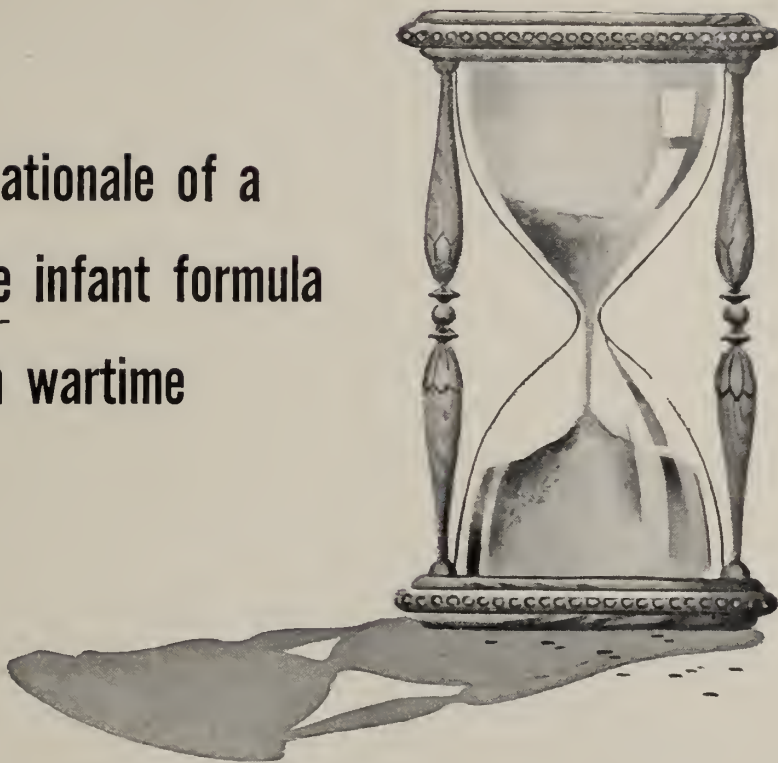
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"3. Conversely, if he should be granted a C book, he can return to the local board, at the end of the three months period, all unused coupons accruing to him as a result of a quite natural overestimation of needs or of overgenerous 'tailoring' by his board, instead of using such coupons for nonessential purposes. The moral effect of such an act on his fellow citizens will be incalculable.

"4. He can set an example by scrupulously observing the 35 mile speed limit, except in cases of emergency, in spite of the fact that doctors could easily 'get away with it.'

"5. Should he be assigned to a hospital, clinic or institution after a ration card for calling on his private practice has been issued, he can use public means of transportation at the price of personal inconvenience.

"6. He can refrain from any kind of driving whatever which might appear to be nonessential in the eyes of the public.

"Doctors are the leaders and molders of public opinion in their communities. If the average man has any reason to believe that the professional men whom he regards with great respect are indifferent or hostile to the mileage rationing program, it will be difficult, if not impossible, to make it effective. Conversely, if doctors as a group observe the letter and spirit of the Regulations, they will be a powerful force in making this absolutely mandatory war measure serve its purpose. We know that we can rely on the support of your profession, which has demonstrated its patriotism, ability and unselfishness at every opportunity.

"John R. Richards,

"Chief Gasoline Rationing Branch, Office of Price Administration."

Commenting on Mr. Richards' letter, The Journal says that "It calls on the medical profession not only to comply

fully with the actual stipulations relative to the rationing of gasoline and tires but also to go beyond such limitations into the spirit of the effort which is so intimately concerned with the winning of the war. Doctors should adhere religiously to the provisions of the Regulations and should set an example to all other persons in the community by the economy with which they use these materials. When Mr. John R. Richards says that doctors are the leaders and molders of public opinion in their communities, he recognizes the dependence of the public on medical leadership in all matters concerned with health. Already such recognition has come from the director of the Fuel Rationing Division. Physicians are authorized to certify invalids, old people and infants for extra fuel oil. Mr. Joel Dean, director of this division, points out that the rationing boards will naturally rely largely on physicians' certification. He says 'If these auxiliary rations are granted with unjustified liberality, the effectiveness of the entire effort to distribute this scarce commodity equitably and to assure continuance of oil for industrial processes in war plants will be jeopardized. I am sure that the medical profession, when it realizes the seriousness of this additional responsibility, will discharge it conscientiously and patriotically.' The patriotism of the medical profession has never been questioned. In this great war physicians have demonstrated their support by their magnificent enlistment in the armed forces and by assuming innumerable obligations in relationship to the control of civilian life. Let us, by the manner in which we aid in the programs for the rationing of fuel, gasoline and tires, demonstrate again to the people of America that confidence in and dependence on the medical profession is well warranted."



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HEALTH MEASURE TO COUNCIL

The Kansas State Board of Health recently approved and sent to the Research Department of the Kansas Legislative Council a measure advocating joint public health services in cities and counties of the state, primarily to meet the needs of the more sparsely settled areas. The Laws which are now in effect were passed in 1885 and do not authorize joint health districts, and those now in existence are operating without a satisfactory legal basis.

It is believed that the Bill as presented by the Board to the Legislative Council on October 14 is of great interest to the profession and is therefore printed in its entirety.

With the increase of war industries in the state and the advent of thousands of war workers, serious health hazards may result. Problems of sanitation, water supply, sewage disposal, housing shortage, food, medical and hospital care may become critical in counties totally unprepared for the great increases in transitory workers and their families.

It has only recently been reported that the contagious diseases rate in the state are on the increase during the past few months and this rate will continue to rise unless local officials are given precautionary facilities to safeguard the lives and the health of the public.

The tentative measure as presented to the Council by the Board of Health is as follows:

TENTATIVE BILL

TO AUTHORIZE FULL-TIME HEALTH DEPARTMENTS IN CITIES AND COUNTIES

"Section 1. Each county in the state is hereby authorized to create a local board of health. The board of health when created shall consist of not more than five members, of which two, shall be doctors of medicine, one dentist and

the remainder non-medical persons. Members shall be appointed by the board of county commissioners, for the stated terms of from one to three years, so arranged that the terms of not more than two members, shall expire in any one year.

"Section 2. Each local board of health, thus created, is empowered to establish a department of health for the county and appoint a director for the department, who shall be a doctor of medicine, preference being given to one who has been trained or who has had experience in public health work, together with other needed personnel.

"Section 3. Each local board of health shall have supervision over the health of the inhabitants of each county in which it is located and is hereby authorized and directed, through the appointed director and personnel of the health department, to enforce the public health laws of the state and the rules and regulations of the state board of health, including those pertaining to food and drugs, water and sewage, and industrial hygiene and sanitation, and such local board of health through its health department director and personnel, when so delegated by municipalities, shall enforce all ordinances relating to health and sanitation which shall be adopted by any municipality in the county wherein it is located, within the corporate limits of any such municipality. Each local board of health shall have the same powers and functions as authorized by law to any board of health.

"Section 4. In event any county is unable to have a department of health because of its size, small population, or lack of finance, two or more adjacent counties, with the consent of the state board of health, are hereby authorized to join and constitute a health district out of the counties so uniting, and may create a common board of health. Said



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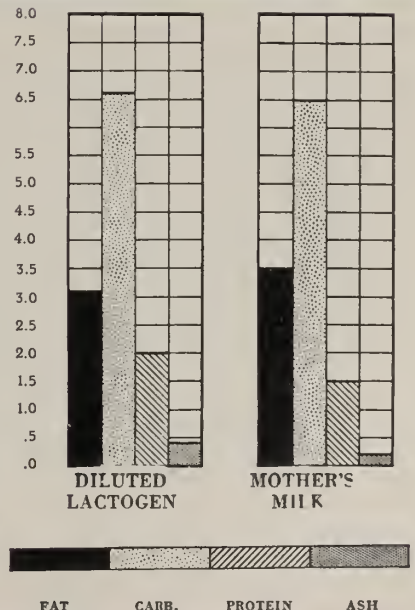


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—John Lovett Morse, A.M., M.D.,
Clinical Pediatrics, p. 156.



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board, when created, shall consist of not more than nine members, of whom four, shall be doctors of medicine, one dentist, and the remainder non-medical persons. The members shall be appointed for stated terms of from one to three years, so arranged that the terms, of not more than three members, shall expire in any one year. Each district health board shall create a district health department comparable to the county health department and each district health board and department shall have the powers granted to local boards of health and to local health departments.

"Section 5. Any municipality may create a local board of health and establish a health department. When a county, or counties, create a health department, all other local or municipal or county public health agencies and departments are thereby automatically abolished and said county and district health departments shall have full control over all health matters in said county and counties, including all municipalities therein, but subject to the supervision, direction and jurisdiction of the State Board of Health: Provided, however, that the proper authorities of any municipality may cooperate with the county in the

establishment and financing of a city-county board of health, and a city-county health department. When any city of more than 60,000 population establishes a full-time health unit all other local or municipal or county public health agencies and departments are thereby automatically abolished and said county commissioners shall participate in the organization and financing of a city-county board of health and city-county health department. Said board of health when created shall consist of not more than nine members of which four shall be doctors of medicine, one dentist and the remainder non-medical persons. Members of the board shall be appointed by the county commissioners and the city governing body at a ratio, using as a basis the population distribution in the city and county at the time of the last census. Members shall be appointed for stated terms of from one to three years, so arranged that the terms of not more than three members shall expire in any one year. Said city-county board of health, when created, shall have all powers granted local boards of health.

"Section 6. Members of local boards of health shall

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Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60

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serve without compensation and shall not hold any public office.

"Section 7. Each county in a district health unit and each city and county cooperating in the organization of financing of a city-county health department shall contribute to the expense and maintenance of such district or city-county health department in the proportion that the population of such county or city bears to the entire population of the combined health district.

"Section 8. Each local board of health and each district health board shall annually, when county budgets are prepared, prepare a budget sufficient to cover the necessary expenditures of the county, city-county or district health department and shall submit such budget to the board or boards of county commissioners or governing bodies of cities, as the case may be, for their consideration and adoption.

"Section 9. The board of county commissioners and governing bodies of municipalities, are hereby authorized to levy tax, not to exceed one-half mill to meet their share of the budget as submitted by the local or district board of health. The tax hereby authorized may be levied and collected without regard to any tax levy limitation or restriction contained in any law, general or special and this act is supplemental and cumulative to any and all laws relating to tax levies.

"Section 10. All revenue provided for in sections seven and eight hereof shall be converted into a county health fund and shall be used exclusively for the support of the county or district health department, and all expenditures from said county health fund shall be approved by the county or district health officer.

"Section 11. The physician appointed as county health officer and director of public health shall, before entering his office, be subject to the approval of the State Board of Health, and shall hold his office during the pleasure of the local board of health or of the State Board of Health, but such physician may be removed for cause at any regular meeting of the local or State Board of Health having majority of the members voting therefor.

"Section 12. The director of the health department, or county health officer, in each county may, with the approval of his local board of health, employ such nurses, sanitarians, clerks and personnel as may be necessary to efficiently operate his office and perform the duties placed on him by this act, the State Board of Health, or his local board of health. He is further authorized, empowered and directed to maintain supervision and authority over the activities and duties of all public health employees, including public health nurses in his county.

"Section 13. For any failure or neglect of said health director to perform any of the duties prescribed by the legislature, the State Board of Health or his local board of health, he may be removed from office by the State Board of Health or his local board of health.

"Section 14. The local board of health is empowered, in its discretion, to acquire by gift, donation or purchase necessary real estate on which to erect, construct or reconstruct public health buildings and clinics sponsored by the public health department. The board is further empowered to accept funds; private, state or federal, to aid in the administration, promotion and operation of health activities."

LEGISLATIVE MEASURE

It is believed that several Legislative Measures pending in Congress are of interest to the membership one of which is herein quoted in brief as furnished by the American Medical Society Bureau of Legal Medicine and Legislation:

"Soldiers' and Sailors' Civil Relief Act Amendments.—This bill H. R. 7164, lacks only the approval of the President to become a law. The report of the conferees appointed to adjust the differences in the bill as it passed the House and as it passed the Senate has been adopted by both houses of Congress. As previously reported this leg-

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isolation will effect many changes in the Soldiers' and Sailors' Civil Relief Act of 1940, making available further relief and benefits to persons in military service. Among other things, the provisions of the original act will be extended to transactions occurring subsequent to October 17, 1940, the new legislation will extend the benefits of the act in connection with insurance premiums to policies up to \$10,000 face value and additional relief will be granted in relation to leases that have been entered into by persons who subsequently go into military service. Of particular interest to the medical profession is the provision authorizing the cancellation of leases on property used for professional purposes. An adequate analysis of this legislation will be prepared after the President affixes his signature to the measure."

The following statement appeared in the September 12, 1942, issue of *Trends*, a periodic review of happenings in Washington published by Congressional Intelligence, Inc.:

"**Civilians to Feel Doctor and Drug Shortage Pinch**—Civilian population health problems take second place behind the armed forces. Many smaller towns may be left without doctors and larger towns and cities will have fewer than during last decade. Restrictions on amounts and usage of certain drugs and near-prohibitions on others are in view because of shortages of particular chemicals. The trend is definitely in the direction of Federal, State and local public health agencies to handle civilian medical needs for the duration, a step toward group (social) medicine."

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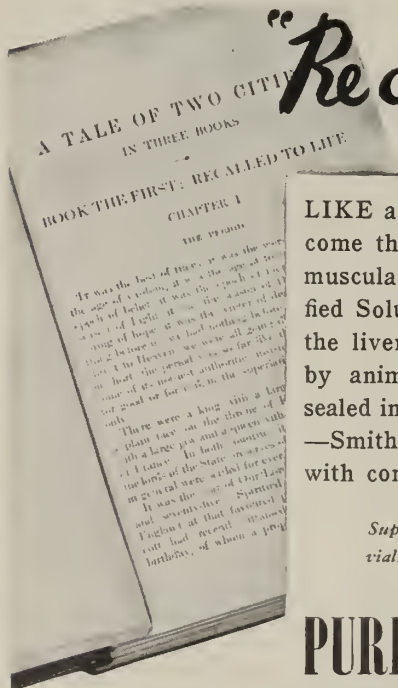
COUNTY SOCIETIES

The Clay County Medical Society held a meeting on October 21 in Clay Center at the Municipal Hospital. Dr. H. L. Hiebert of the division of tuberculosis of the Kansas State Board of Health talked on "Tuberculosis" and showed moving pictures on the subject.

The Golden Belt Medical Society held a meeting in Salina on October 15 with the Salina County Medical Society as host. Officers for the organization are: Dr. E. Raymond Gelvin of Concordia, President, and Dr. L. S. Nelson of Salina, Secretary. Speakers on the program were as follows: Dr. R. R. Sheldon, who spoke on "When to Operate," Dr. Leo J. Schaefer who discussed "Sulphonamides," Dr. John Mitchell who spoke on "Fluid Balance," Dr. Porter Brown who spoke on "Hemorrhage," Dr. E. M. Sutton whose subject was "Detachment of Placenta," Dr. L. W. Huttan who spoke on "Soft Tissue Damage," Dr. Earl Vermillion who spoke on "Placenta Praevia," Dr. J. A. Simpson who discussed "Bleeding Before Labor" and Major A. A. Towner, commanding officer of the Salina Army Air Base Hospital who spoke on "Aviation Medicine." Dr. Henry N. Tihen, President of the Society was the speaker at the dinner meeting.

The Sedgwick County Medical Society held a meeting in Wichita on November 3. Dr. Hugh G. Jeter of the Oklahoma University School of Medicine spoke on "Paracenteric Fluid as an Aid in Diagnosis," and Dr. Harry Wilkins, also of the Oklahoma University School of Medicine spoke on "Injuries to the Covering of the Brain."

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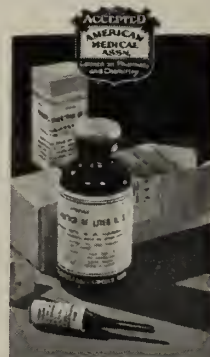
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The Labette County Medical Society and the Kansas Crippled Children's Commission sponsored a crippled children's clinic in Parsons on November 6. Dr. C. B. Francisco of Kansas City assisted the groups in the examinations.

The Leavenworth County Medical Society and the Kansas Crippled Children's Commission sponsored an all day clinic in Leavenworth on November 4. The organizations were assisted in the examination by Dr. Frank D. Dickson of Kansas City.

The Wyandotte County Medical Society held a meeting in Kansas City on October 20. Dr. G. M. Tice of Kansas City spoke on "Retino-Blastoma." Dr. T. V. Oltman, a medical missionary who was captured in China and held by the Japanese, being later released to the United States discussed his experiences.

DEATH NOTICES

The Journal wishes to make a correction in the death notices published in the September issue. The second item should have read as follows: "Dr. William Kirk Fast (not Frost), 53 years of age, died on August 31, at his home in Atchison."

Dr. Arthur J. Anderson, 79 years of age, died on October 8 at his home in Lawrence. Dr. Anderson was born in Greenfield, Ohio, on January 19, 1863, and was graduated from the Hahnemann Hospital and Medical College of Chicago in 1887. He was a member of the Douglas

County Medical Society of which he was president for five years.

Dr. Arthur D. Gray, 56 years of age, died on October 30 at his home in Topeka. He was educated in Topeka and



graduated from the Kansas Medical College of Topeka in 1912. He was a member of the Shawnee County Medical Society, the American College of Surgeons and various urological organizations.

Many thanks for your splendid co-operation during the past few weeks. With the unusual demands placed upon our hard hit personnel, your kind understanding enabled us to do a job which otherwise would have been impossible. *Again Many Thanks.*

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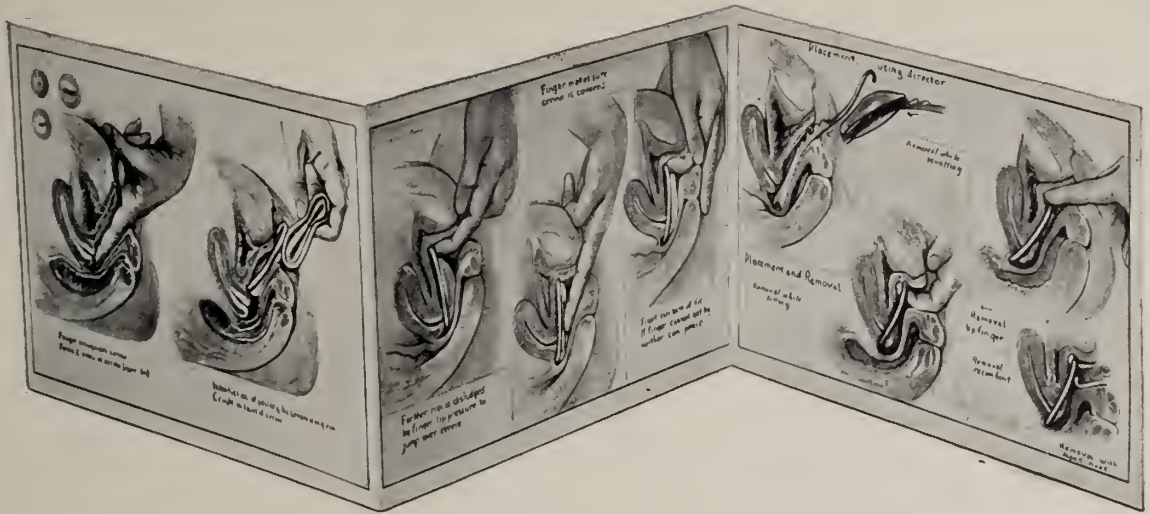
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Dr. Andrew J. Dodds, 85 years of age, died at his home in Pittsburg on September 18. Dr. Dodds was born in Athens County, Ohio, on August 5, 1857, and was graduated from the Medical College of Ohio in Cincinnati in 1885. He was an honorary member of the Crawford County Medical Society.

Dr. Jasper D. Johnson, 67 years of age, died of coronary occlusion at his home in Alton on September 11. Dr. Johnson was born in Summerfield, Missouri, on March 12, 1875. He was graduated from the College of Physicians and Surgeons of Kansas City in 1902 and was a member of the Osborn County Medical Society.

Dr. John Wesley Johnson, 78 years of age, died on October 25 at his home in Inman. He was born at Athens, Ontario, Canada, on August 2, 1864, and was graduated from the McGill University Faculty of Medicine of Montreal, Canada, in 1887. He was an honorary member of the McPherson County Medical Society.

Dr. George Campbell McKnight, 76 years of age, died on October 8 in Hiawatha. Dr. McKnight was graduated from the Rush Medical College of Chicago, Illinois, in 1891. He was an honorary member of the Brown County Medical Society.

Captain Raymond C. Stiles, M.C., United States Army, 30 years of age, was killed in the crash of a United States Army transport on September 3, near Coamo, Puerto Rico. Dr. Stiles was graduated from Baylor University College of

Medicine of Dallas in 1937. He was a member of the Wyandotte County Medical Society before his entrance into the Army three years ago.

Dr. William Henry Updegrave, 64 years of age, died on August 19, at his home in Pittsburg. He was born on September 2, 1877, at Pottstown, Pennsylvania, and was graduated from the Southwest School of Medicine and Hospital of Kansas City, Missouri, in 1909. He was a member of the Crawford County Medical Society.

KANSAS MEDICAL ASSISTANTS SOCIETY

Miss Pearl Scott, Councilor of Kansas City, has recently resigned her position to accept an appointment in the W.A.A.C. and therefore a new councilor will be appointed from that district to fill her unexpired term.

Mrs. Mildred McClure of 811 Huron Building, Kansas City, Kansas, is the chairman of the newly organized Honor Roll Committee. Any one having information regarding former members of the Kansas Medical Assistants Society who are now serving in the United States Army, Navy, as nurses or in other capacity will please inform Mrs. McClure. The organization is attempting to keep up to date on this material.

News of meetings of the local groups of the Kansas Medical Assistants Societies must be forwarded to the Journal office not later than the first week in each month for publication

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AUXILIARY

PRESIDENT'S MESSAGE

Dear Members:

Since our Board meeting last month, I have attended a meeting of the Kansas Council of Women in Topeka, where plans were made for a one day session in that city on January 30. The Kansas Medical Auxiliary is a member organization of the Council, being represented by its president. From the reports of the presidents of other organizations I obtained the following suggestions which some of you may want to consider:

1. Learn the "American's Creed."
2. Work up a history of medicine in your county, to be compiled into a state history, which would be accessible to anyone wanting such information.
3. Encourage and help girls with necessary qualifications, to take up nursing, thereby releasing trained nurses for service with the armed forces.

I have also on file names of prominent women speakers in this territory who might be available for your program.

I am now looking forward to the mid-season Board meeting of the National Auxiliary in Chicago on November 20, although by the time you read this message it will probably have already taken place. I expect to get some worth while ideas to pass on to you in the next issue of the Journal or news letter.

May I wish each of you a happy Thanksgiving? From the reports of the war now coming over the radio this first part of November, it seems as though we are indeed going to have much to be thankful for on Thanksgiving Day.

Sincerely,

Mrs. C. Omer West.

AUXILIARY NEWS

The first fall meeting of the Sedgwick County Auxiliary was held in Wichita on October 12. Miss Jessica Smith of Wichita spoke on "Alaska Our Last Frontier." Dr. Henry N. Tihen, President of The Kansas Medical Society, gave a short talk. The November 9 meeting of the organization had a speaker from the local Community-War Chest who discussed the 1943 campaign.

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The Journal Of THE KANSAS MEDICAL SOCIETY

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Volume XLIII

DECEMBER, 1942

Number 12

FUNDAMENTALS OF PSYCHIATRY III

MENTAL HYGIENE

William C. Menninger, M.D.

Topeka, Kansas

The term Mental Hygiene is one of those twentieth century productions which has become familiar to a good many people, though not many of them know exactly what it means. Most doctors and nurses have heard of it and a good many teachers, clergymen, and social workers have made use of it. In general, however, it is still something vague but because they know what the words mental and hygiene mean they can safely assume that it has to do with the hygiene of the mind. Beyond this it has no definite meaning for most people.

After years of public education the average intelligent layman has no difficulty whatever in formulating certain principles about his physical hygiene. He recognizes the significance of the term and knows that it refers to important factors in physical health such as diet, sleep, exercise, fresh air, cleanliness. This same layman (or perhaps a doctor or nurse) though, would probably have some difficulty in formulating similar principles for mental hygiene. We have learned, however, that one cannot separate the physical from the mental health, for when one is affected the other is affected in some degree also. One can apply literally the rules of physical hygiene to any expression of the total personality. For instance, it is often desirable for one to change the climate of his emotions; when any situation becomes so difficult that one becomes over-emotional, he needs either to change the situation or exclude himself from it. We hang up posters in the school room and listen to radio talks about the necessity for keeping the teeth clean, but rarely do we hear anyone urging the brushing of our mental teeth—a simple thing to do by reading, studying, or carrying out a research project. Rarely do we hear anyone suggesting that we give our minds a bath, or emphasizing the necessity of getting rid of our unsavory habits,

by taking regular recreation and vacations. One needs recreation not only for the benefit of the physical exercise, but because it is an established fact that comparative few people with satisfactory avocations develop serious mental breakdowns.

The maintenance of mental health is a complicated problem because man himself is a complicated machine, always in action, continuously attempting to achieve something, whether it be trying to make a home, to build a business, or to win a girl. In everyday life we are trying continuously to achieve some aim against odds—trying to study chemistry against the odds of the roommate's chatter, trying to get a patient to take some medicine when he doesn't want to, trying to reassure a relative who doesn't seem to want comfort. At every instant we are attempting to organize ourselves to meet a constantly changing situation, a process which the psychiatrist calls adjustment. Sometimes this adjustment process becomes very difficult; a conflict may arise because we wish to do or to be something which the world won't accept; or on the other hand, the world may impose a demand upon us which we cannot accept. When an individual fails to solve such a conflict in an efficient, satisfactory way the failure may manifest itself in many ways—in temper outbursts, in irritability, in depression, in over-activity, in seeking seclusion, by putting the blame on someone else. These kinds of failure the psychiatrist calls symptoms—the symptoms of mental ill health—and he does not regard them as a form of sin, or meanness, or perversity, or feeble-mindedness. In most instances the conflict can be understood and many times the individual can be helped through changes effected in himself or in the environment. This personality-environmental friction is frequently not perceived by the average person as a struggle, and consequently, many persons develop one or more of these symptoms only because of ignorance of the general principles of mental health. It was for the purpose of helping both the mentally healthy and the mentally ill toward a knowledge of these principles that the Mental Hygiene idea and Movement were inaugurated. We may define Mental Hygiene, then, as the preservation of mental health and the prevention of mental ill health.

THE MENTAL HYGIENE MOVEMENT

As a term Mental Hygiene was first used in 1843 by Sweetser, and again by Ray in 1863. In neither instance, however, did the author stress the concept as anything particularly new or particularly helpful. It remained for a layman, Clifford Beers, to crystallize the idea of mental hygiene in 1907 (following a very unhappy mental sickness over a period of several years) as an aid for those individuals who had endured a suffering similar to his own. He gathered together a group of men—psychiatrists, clergymen, lawyers, educators—to start a movement in 1909 which was named The Mental Hygiene Movement by Dr. Adolf Meyer, and directed originally by Dr. Thomas W. Salmon. This group, which called itself the National Committee for Mental Hygiene, stated its purpose as being "to serve as a clearing-house for the nation on the subject of mental health, the prevention of nervous and mental disorders, and the care and treatment of the insane."

During the twenty-five years since its organization this movement has grown tremendously. Its accomplishments are as spectacular as they are numerous, and it requires ten pages of small print to list them in the Twenty-fifth Anniversary Edition of Mr. Beers' autobiography "A Mind That Found Itself." In brief, this organization has now grown to include twenty-seven state organizations, and literally hundreds of community organizations. It has become international in scope and is organized as a definite movement in thirty-two countries. In our own country this organization has done a vast amount of educational work regarding mental ill-health. It has improved the laws controlling mental hospitals in many states, and it has improved the treatment and living conditions in many of these hospitals. Through its efforts, a uniform system of classification of mental disease has been adopted throughout the country. It has developed a statistical system for use in state hospitals. It has established a great number of psychiatric clinics for children and adults, and has also been instrumental in introducing psychiatry into the courts and penal institutions. It has fostered the application of psychiatry to the problems of industrial workers. It has aided materially in the formulation of mental hygiene divisions in many state public health departments.

MENTAL HYGIENE TO DATE IS CHIEFLY SOCIAL AND FORENSIC PSYCHIATRY

The Mental Hygiene Movement has done and is doing an exceedingly important work and its scope covers a very broad field, including the application of the principles of mental health to the entire structure of society. Its failures, if they may be called such, are in no sense due to the Movement itself. The fact

remains, however, that the prevention of any illness is possible only when the cause is known. Psychiatry so long confined itself to describing various kinds of mental diseases rather than trying to find their causes, that the Mental Hygiene Movement has had to function chiefly as an aid to those who were already mentally sick. In other words, its chief field has been in social and forensic psychiatry, and not in prophylaxis.

One of the great challenges in psychiatry and particularly in mental hygiene is to develop this prophylaxis for mental ill health. The greatest help has come from the knowledge gained through psychoanalysis; but psychoanalysis as a treatment method is not mental hygiene. The task remains to apply over a broad social vista the information gained from this and every other available source to prevent mental illness.

PSYCHOANALYTIC CONTRIBUTIONS TO MENTAL HYGIENE

Probably the most important contribution as learned from psychoanalysis has been this concept of a conflict—a conflict as described above—in which the individual's expressions in the form of symptoms are seen as the results of his inability to adjust. An equally important contribution from psychoanalysis has been the recognition of the importance of the role played in the causation of mental illness by the infantile and childhood emotional relationships in the family. From the knowledge we have gained we can assume that the childhood period is of paramount importance in mental health; in fact, it is the major field for the institution of prophylaxis against mental ill-health in later life. Consequently, because of its fundamental importance the primary responsibility for the practice of mental hygiene lies with the parents and the teachers of our children.

It may be helpful to point out common examples of what may be regarded as "bad mental hygiene" so frequently employed by parents. Psychoanalysis has taught us, for instance, that corporal punishment of children is motivated in most instances by hate on the part of the parents for the child. It engenders only fear and hate in the child, and a desire for retaliation. In lay terms, it satisfies no one but the parents. Similarly, we have learned to regard over-protection on the part of parents as a factor in the production of later mental ill-health. Over-protection of a child by parents is usually recognized by everyone except the parents. Everyone else can see that it is doing the child harm, and yet the parents do it under the guise of affection. Another common error of many parents is the assumption of an alternating attitude of severity and indulgence—to punish the child and then offer gifts. It is as if at one moment the parents are

annoyed and must express hate toward the child, and then feel guilty about it and want to overcompensate by loving the child a great deal; and the parents are usually entirely unaware of these fluctuations in their own mood and behavior.

Nor can one trust common sense to see these mistakes, because in the great majority of instances the parents are not even aware that they are making mistakes. Even if it is pointed out to them they usually present some excuse or reason which they resolutely assume to be a justifiable one. It is often quite impossible for them to understand the attitudes of the child. The child's behavior may reflect fear or insecurity, as for example in the case of a child who thinks that he can get attention only by showing off, or perhaps even by misbehaving. Perhaps even more often the child attempts to obtain love through provocative behavior, which is rewarded only with punishment.

GUIDING PRINCIPLES OF MENTAL HYGIENE

Unfortunately as yet one can be none too definite in giving rules or regulations to follow as guiding principles for parents or teachers in mental health. From time to time one hears a series of rules to govern mental health, such as "Know thyself," "Don't worry," "Make clean-cut, practical decisions," "Keep smiling." Most psychiatrists regard these adages as well-meaning but unimportant, and certainly not "mental hygiene." Perhaps because they are platitudes they are never taken seriously. One may know them but when it comes time to use them, one doesn't.

There are, however, some general formulations about mental health which are helpful to know, and which may be regarded as guiding principles for the establishment and maintenance of mental health.

1. Security. Perhaps least understood by parents is the necessity for the child to feel secure, to know that he is loved, to know that he has protection, to know that he is going to get a fair deal. The parent ordinarily thinks he gives the child all of these, yet again, is unaware of the times when it may appear to the child that the baby brother is getting more affection than he is, or that big brother is getting all the new clothes and he is getting big brother's outgrown clothes. Because the child can't verbalize these feelings the parent may be entirely unaware that little sister gets the small end of things—big sister is the favorite, she has the privileges, she has the confidence. But little sister is not to be fooled by any occasional extra amount of attention which the parents give her.

Every child needs to feel secure and when he does not he may manifest timidity, may be over-familiar with strangers, may demand much attention from his parents, or may show other misbehavior.

2. Gratification. A second general principle in mental health is to recognize that every child, in fact every adult, strives for gratification of basic emotional needs. In childhood we recognize that the methods of obtaining gratification are primitive, literally "childish." The child may suck his finger, he may jump or stamp his feet, he may make a broom into a charging steed. As he grows up he has to change his methods of finding gratification to meet the demands of the adult world. His methods of obtaining affection must change. He has to change his social relationships. He has to learn to meet economic demands. All of these changes must be gradual evolutions, however, and too often the parent is inclined to cut off the childish methods abruptly, to fail to see that it must be a slow change and a gradual education of the child. On the other hand, the parents may be prone to attempt to continue these childish gratifications too long; they want to baby the child until he is ready to go away to college and then discover that as a result of babying he is entirely unprepared for this advance. Can parents give a child too much love so that they spoil him? Certainly, a child can be spoiled by the parents because their over-indulgence leads him to expect more from the world than it will give him. One must conclude that in such instances the parents' attention can hardly be called love. The result for the child is that he is crippled because the parents' "love" was a disguise for unconscious hostility and unconscious guilt.

3. Parental Tolerance. A third guiding principle is the recognition of the complexity of this environmental-personality struggle, as it applies to the child. Parents are too prone to forget that the child must learn a great deal, much of which adults are likely to take for granted. The child can't eat like a grown-up; he has to learn to eat like a grown-up. He can't behave in front of company like a grown-up; he should not be expected to, yet the parent may expect him to and scold him when he doesn't. The process of growing up is a slow one and in psychiatry we learn that the childish behavior of many adults results because their parents stood in the way, pushing them at the wrong time, or holding them back when they should have gone ahead.

4. Recognition as an Individual. A fourth guiding principle in mental hygiene might be summarized as respect for the individual. The expression "he's only a child," may sometimes signify sympathy, but more often it carries contempt. It is all right for a father to interrupt a child's conversation, but it is a punishable offense for the child to interrupt the father. When the child is small the parents should accept the responsibility of modifying the environment to fit his needs, rather than expecting the child to mold himself to the environment. The wise

parent can follow this out in a thousand ways: to provide child-size furniture, to provide clothes hooks for his height and not for his parents' height, to place his looking glass where he can see himself, to recognize that the experiences of his day are just as important as father's, etc.

APPLICATION OF MENTAL HYGIENE

The maintenance of one's mental health is a twenty-four-hour-a-day job. Every day we fail in some ways, i.e. we neglect something we should do or we waste time, we are inconsiderate of someone, or may over-indulge some one else, we lose our temper, we don't want to do a job and compromise by doing it poorly, we forget an important appointment, and so on. Every minute we are making some kind of an adjustment, for better or for worse. In view of this fact one can readily understand that theoretically the field of mental hygiene applies to everybody and in every sort of situation. In fact the principles of mental hygiene have been applied not only in the home but in the school, the church, the court, social work, and in many other situations. Furthermore there is an increasingly wide recognition of its need, and a rapidly extending application of its practice.

Mental Hygiene in Education. We have taught physical hygiene in our schools for many years, but only within the last fifteen years has mental hygiene been offered to our students. At the present time a great many of our leading universities and colleges not only give courses in mental hygiene, but provide a counselor service. In personal interviews the student may discuss with a psychiatrist his personal problems, how to study, why he failed in algebra, why he comes late to class, why he didn't make the fraternity, why he can't recite in class, and similar minor problems. Or he may be unhappy or moody and not know why; he feels inferior to those about him; he may have some definite fears. For these evidences of mental ill health, he may avail himself of help. Mental Hygiene service is being provided in a great many of our secondary schools, particularly the high schools, to solve student problems of all sorts. In many institutions courses are now given for parents on child care, and on Mental Hygiene as applied to the adult.

A few communities have made a start toward a Mental Hygiene service for even the primary grades in the form of what are known as visiting teachers. For many years we have examined the eyes, ears, and tonsils of our children, and in most places the report card carries a notation of the actual and the normal weight. It is only recently, however, that educational leaders have recognized the desirability of paying attention to the child's mind, particularly in the in-

stances of backward children; those who seem to understand one subject but don't grasp another one, those who are behavior problems in the classroom, and in general those who reflect in a wide variety of ways the difficulties carried over from the home.

Industry: Mental Hygiene has a tremendous field in vocational education and guidance. Not only can it contribute a great deal through the psychological, vocational and performance tests applied to the individual, but particularly through a consultation service to evaluate personality characteristics, on the basis of which advice can be given regarding vocational choice.

Of equal importance is the contribution that Mental Hygiene is already making in the field of industry. Almost every large industrial concern employs personnel men. In many instances these men receive special training in Mental Hygiene. In a few instances certain large industrial and business concerns have found it highly profitable to maintain a mental health service in charge of a psychiatrist. The function of such a service is to investigate all types of employees' problems—the employee who comes late, the one who can't get along with the customer, the one who can't get along with his fellow employees, the one whose emotional conflicts interfere grossly with his efficiency. This field is only in its infancy. At the present time, most large industrial concerns recognize the responsibility and in fact the self-protection, in maintaining an adequate health program for its employees. Unfortunately, this is too often limited to physical health, with even elaborate hospital systems, full time physicians, nurses, and with little or no attention to the mental health.

Child Guidance: The guidance of children has been included in psychiatry only relatively recently, and now is a part of the practice of many psychiatrists. The term child guidance is usually applied to a movement which was started by Dr. William Healy in 1909 and extended by the Commonwealth Fund Demonstration Clinics in 1922. There are now a series of special clinics in many of the larger cities in the United States, in which there is a full time staff of psychiatrists, psychologists, psychiatric social workers, and nurses. It is the purpose of the clinic to examine, diagnose, and treat all types of behavior problems occurring in children. It has perhaps been the most effective mental hygiene work that has been accomplished, insofar as it applies to the golden age for prophylaxis—childhood, and yet again, these clinics deal chiefly with children who already have become maladjusted.

Delinquency and Criminality: A survey made by the Mental Hygiene Movement in 1928 showed that ninety-three penal and correctional institutions were

employing psychiatrists for full or part time, and 115 courts were using psychiatric services of their own, or those furnished by available community clinics. It is the purpose of the psychiatric counsel in these situations to apply the psychiatric viewpoint to delinquencies, trancies, petty offenses, and crimes, with the purpose of making recommendations as to the subsequent handling of the offenders. Psychiatry has contributed tremendously to the understanding of criminality, but as yet one can consider that its contribution has been applied to merely the surface of the need.

Social Work: One may say that social work is rapidly becoming permeated with the psychiatric point of view. Perhaps no group who deal with mass humanity have so enthusiastically recognized the advantages, in fact the necessity, of a psychiatric background. Practically every recognized school of social work at the present time includes certain elementary courses in psychiatry. The field has become so important that several high grade special schools for psychiatric social work have been organized. One may make the general statement that practically every organization which carries on social work in a large community numbers among its staff at least one psychiatrically trained social worker.

Public Health: Through the efforts of the Mental Hygiene organization a few states have instituted a Mental Hygiene Division in their public health organization, notably New York, Connecticut, Pennsylvania, Illinois, Massachusetts and a few others. Unfortunately, the majority of states are still backward in this regard, and while their public health services for the most part are of high standing and do a highly commendable work they completely ignore the responsibility of informing the public regarding mental health. In justification, one may say that this is not necessarily due to the public health officers themselves, but it requires time, effort, energy, and a long campaign of education to persuade legislatures to include this in the state program. The need can be bluntly expressed in the statement that there are more deaths from one symptom of mental illness, namely suicide, than there are from the combined mortality of diphtheria, typhoid, pertussis, scarlet fever, and measles. The lack of such a division in our public health organizations is the more difficult to understand when we recognize the number of mentally ill people and the almost unbelievable amount which the public spends for their care. Statistically, it is known that one out of every twenty-two persons in this country will develop a mental disorder of a severity sufficient to require hospital treatment at some time in his life. Between 60,000 and 70,000 new cases are admitted to state mental hospitals every year, and the population of these institutions is in-

creasing roughly about 14,000 a year. For the 300,000 odd patients under care in state mental hospitals our taxpayers pay approximately \$200,000,000 a year to maintain this hospital care and treatment.

In Nursing: In no field unless for the physician is a knowledge of psychiatry and mental hygiene more essential than in nursing. Not only can this knowledge be of tremendous benefit to a nurse in the solution of her own emotional problems but there is a growing attitude held by the leaders in the nursing profession that psychiatric training is essential for every nurse. As was explained in the first chapter, the psychiatrist looks at man as a total psychosomatic unit and regards any disease as an expression of the total personality. The nurse has the job of taking care, not of a diseased gall-bladder or of a broken leg, but of a personality of which these are partial expressions. She faces the continual job of adjusting herself to the patient and helping him adjust himself to his conflict, whether it be chiefly an organic or a mental illness. Unless she has had sufficient background to understand how the personality is made up, how it works, and how to take care of its jams, she is necessarily incomplete in her training.

Even if the nurse erroneously believes that a knowledge of psychiatry and mental hygiene is not necessary in taking care of a post-operative case, or a physical illness of some other type, she cannot help but know that approximately fifty per cent of patients who come to see the physician have no organic disease. How then is she to handle these, when she knows that their symptoms are the result of psychological or emotional jams? The nurse without psychiatric training is almost at a total loss in attempting to take care of the frankly neurotic individual and she is much beyond her depth in attempting to care for a psychotic patient.

As has been stated, the leaders of the nursing profession are keenly aware of the necessity for psychiatric training. There is an increasing demand on psychiatric institutions for affiliations from general hospitals. There is a very greatly increased demand for nurses with post-graduate training in psychiatry, not only for clinical positions in psychiatric institutions, but also for executive positions in general hospitals. In several large general hospitals the nurse in charge of every department — pediatrics, obstetrics, surgery, medicine — must have had psychiatric training. In many instances within the last few years, those individuals who supervise out state hospitals have awakened to the fact that psychiatric hospital care by attendants is in no way comparable to the quality possible through psychiatrically trained graduate nurses.

The knowledge of mental hygiene and psychiatric

training is likewise rapidly becoming a necessity to the public health nurse, and also to the visiting school nurse. As the leaders of industry recognize the importance of the mental health of their employees the nurse in industrial medicine will gain a tremendous advantage from psychiatric training.

Mental Hygiene and the Physician: One might assume that the practitioners of medicine are the individuals best informed about mental hygiene and most interested in it. It may be surprising to the layman to know that the great majority of physicians are only passingly interested in the mental hygiene movement and are not adequately informed on the subject. One may justifiably ask, Why is this so? When half the hospital beds in this country are occupied by mental patients and approximately half the patients who consult every doctor have no organic disease, how can they help but be interested?

The answers are many. In the first place, every physician does practice "psychotherapy" though suggestion, advice, encouragement, reassurance, and other methods even though he may not regard or recognize it as such. So at least superficially he is interested in the field of mental health, though perhaps not under the name mental hygiene. Secondly, most physicians have received an inadequate training in psychiatry in medical school (as shown statistically by Dr. Franklin Ebaugh's survey) and the emphasis on teaching the mental expressions of man's ill health is still neglected for the organic disturbances. Although the physician is trained to be an excellent diagnostician of physical disorders, he is too often lost in confusion in attempting to make a mental diagnosis. Most physicians admit this (sometimes almost boastfully) and altho they will ferret out the blood chemistry status of a patient to the nth degree, they are likely to ignore or neglect the problem if it is primarily an emotional one.

Although this lack of training in psychiatry in medical school is undoubtedly the chief reason for the physician's apparent disinterest in mental health there are other reasons. While the physicians in this country as a group decry state medicine, they have applied it in the field of psychiatry for one hundred and fifty years. Furthermore, hospital care for psychiatric patients must be limited to special institutions or to special wards in the general hospital, which at the present time are all too few. Thus, the average physician is placed in the position of being unable to take care of such a patient if hospitalization is needed, even if he wishes. To treat many types of nervous and mental illnesses requires a long period of time, often more than the physician can give. As a consequence, the physician may attempt "short-cut" methods such as giving placebos, giving curt and abbreviated advice or commands to "Forget

it," "Get out and play golf," "Take a vacation," even though he recognizes that such procedures or advice are usually ineffective and unscientific.

The whole field of psychiatry is admittedly complex and to be familiar with it often requires more time than a busy specialist, such as the obstetrician or laryngologist, feels that he can give to it. Nevertheless, the interest in mental medicine on the part of the general practitioner as well as that of many of the specialists is rapidly increasing. The significance of emotional factors in such physical conditions as hypertension, thyroid disorders, gastric ulcer, constipation, is becoming much more widely recognized, and the Mental Hygiene Movement numbers among its most active supporters many physicians other than psychiatrists.

In summary, one may say that the theory and practice of mental hygiene applies to every one at all times and merits the interest and investigation of every man. As an organized movement, a commendable and extensive work has been done. In comparison to the size of the task, it is in its infancy, and when we are able to give specific prophylactic advice, its scope and benefits may reach beyond any limit we can now conceive for it.

SULFATHIAZOLE

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ACTION:—Tissue invasion by bacteria may be prevented by the use of sulfathiazole, the production of toxic substances reduced and the antibacterial immune mechanisms of the host permitted to complete the recovery from infection.

Sulfathiazole is used primarily in the treatment of infections due to the pneumococcus, staphylococcus aureus, gonococcus in both male and female, and hemolytic streptococcus infections.

Sulfathiazole is rapidly absorbed when taken orally. Maximum concentrations of the drug in the blood is obtained in three to six hours after administration of a single dose. It is fairly evenly distributed throughout most of the body tissues, but does not pass readily into the spinal fluid. Almost complete excretion occurs within twenty-four hours after administration.

TOXICITY:—The untoward effects of this chemical are unpredictable in their occurrence and are considered to be the result of an idiosyncrasy to the drug. Drug fever is very common in the course of treatment with sulfathiazole, occurring usually between the fifth and ninth days of treatment, but may occur as soon as thirty minutes after taking the first

dose. Urticarial or nodular rashes resembling erythema nodosum are frequently seen. Hematuria occurs frequently and occasionally leukopenia. Anemia and hepatic damage are rare, with cyanosis uncommon.

DOSAGE:—In the treatment of pneumonia (all types of pneumococci) the suggested initial dose in adults is sixty grains, then fifteen grains every four hours, day and night until temperature has been normal for seventy-two hours.

In staphylococcus infections, the initial dose is fifteen grains and should be repeated every four hours, day and night for from four to six days.

In gonococcus infections, fifteen grains is administered four times a day for a period of five days.

EXTERNAL USE:—Five per cent sulfathiazole in a water soluble ointment base is used in ecthyma, perionychia, and impetigo contagiosa in the later stages. The sodium salt of sulfathiazole (five per cent) in calamine lotion is very effective in the first stages of impetigo contagiosa. An aqueous five per cent solution of the sodium salt is used in staphylococcus conjunctivitis with good results.

ADJUNCTIVE MEASURES:—The fluid intake should be about 2000 c.c. daily during the first days of treatment. This is to prevent dehydration and also to provide sufficient dilution to prevent precipitation of crystals of sulfathiazole in the urine.

Sulfathiazole is not believed to be incompatible with other drugs but saline laxatives had best be avoided. It may be helpful to administer bicarbonate of soda gram, for gram to render the urine so alkaline that the precipitation of acetylsulfathiazole may be hindered or prevented.

General Practice Requires Brilliant Men—There is an idea abroad that medical men drift into general practice because there is no place for them anywhere else. This idea should be disabused. Only brilliant men should go into general practice. In no other field of medicine is competition so keen and in no other field of medicine are the keenest mental qualities required for success. The sphere of general practice is not the place for mental or physical weaklings. In it you work among the people. They know you personally. Your mistakes are made public and are discussed by all. The general practitioner's mistakes are not hidden under a bundle of pathologic and x-ray reports but are discussed in the local public house and at the church on Sunday. It will not bring big financial success, but it brings better things. It brings friendships which are life-long. No other branch of the profession gives such a full life—a life full of real living and of service. Therefore, if you decide to take up general practice, do so with the knowledge that there the greatest field for service as a doctor is open to you.—McCann, J. J.: *The General Practitioner Looks at Medicine*, Irish J. M. Sc., June, 1941; reprinted in the J.A.M.A.

SHAWNEE COUNTY MEDICAL CARE PLAN

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When medical plans for the care of the medical indigent are mentioned, we still frequently hear individuals in the profession make substantially the following comment: "It's socialization of medicine and I don't want any part of it. I'll continue to contribute my services to the poor in the future as I have done in the past." It would be just as reasonable for the doctor who made this comment, to say of the new miracle drug "I've got along without it in the past and I will continue to do so in the future."

In the past twelve years many radical changes have taken place in our economic and social life. The profession must keep pace with these economic and social changes as they have with the rapid advances of medical science during this same period. If we become isolationists or complacent in these matters and wait until the Federal Government sets up standards which are usually planned by lay persons and based solely on pure theory, you may depend on it that we will have socialized medicine in so far as the indigent and low-income group is concerned.

Fortunately a large majority of the profession in Kansas realize the need of organized medical plan for the care of the medical indigent and for the past few years have experimented with various types of plans, some good—some bad.

The so-called prepaid plan has been generally accepted by the profession as well as the State Department of Public Welfare, as socially and economically sound and superior to other types.

It has proven workable and retains the patient-physician relationship which is very essential. The Bureau of Medical Economics of the American Medical Association in their publication "Organized payments of Medical Service" has this to say: "The principle of medical ethics are the only firm foundation on which to base a sound medical service. The county medical society is the only organization occupying the natural geographic unit and possessed of the necessary professional knowledge and the power to maintain the principles of medical ethics in the organization of medical service in a community." The county medical society is not only the logical unit on territorial and professional grounds, but it is also by tradition and discipline founded on

the basis that "Reward or Financial Gain should be a Secondary Consideration."

Now that we are in the midst of a great war and face a serious shortage in the profession for care of the civilian population, it becomes more and more imperative that some sound plan be organized BY AND UNDER THE CONTROL OF THE MEDICAL SOCIETY for the care of the medical indigent. It should be obvious that a well organized plan, in addition to the many other things it will accomplish, will also greatly facilitate the handling of this type of case.

Space will not permit the argument for prepaid plan over the fee basis at this time. There are several counties in the state now operating under plans quite similar to the plan of Shawnee County with perhaps the exception of the all important question as to who controls these plans, wherein lies the answer, the success or failure both economically and professionally. There is no sound argument regardless of the size of the county why the county society should not be in complete control.

After more than a year of negotiations, the Shawnee County Medical Society entered into an agreement with the Shawnee County Board of Social Welfare and the State Department of Social Welfare for the medical care of the indigent of Shawnee County. At that time Shawnee County had more than double the population of any other county that had at that time attempted to operate a similar plan. Several features which were new to Kansas and one which to the best of our knowledge is entirely original were tried. Many said in the beginning that the plan would not work; the county was too large any many other reasons, but after seven months the plan has worked and quite successfully.

The contract consists of seventeen paragraphs, the five basis paragraphs follow:

"Paragraph 3. RATE OF COMPENSATION.—That in consideration of the services to be rendered by Party of the Second Part, as hereafter set out, Party of the First Part guarantees that Party of the Second Part, thru their authorized agent, shall receive the sum of Three Dollars (\$3.00) per month for each assistance grant on the county relief rolls as of the first day of each month.

"That all Old Age Assistance cases, Aid to Dependent Children cases, Blind Assistance cases and General Assistance cases may receive the benefits of medical care as herein defined from Party of the Second Part, if they choose to do so, by making payments at the rate of Three Dollars (\$3.00) per month in advance except payment for all General Assistance cases as above provided shall be made directly to the Second Party by the First Party at the

first of each month. If it appears expedient and practical for each case, lump sum payments may be made in advance. Such advance payments shall not exceed six (6) months and in the event death or ineligibility of the client effected, Party of the Second Part will refund all payments for the months following such death or ineligibility.

"That the agent of the Party of the Second Part, hereinafter named, shall furnish monthly to the Director of the Shawnee County Board of Social Welfare a list of names of the first three classes of assistance cases named in the preceding paragraph, namely, Old Age Assistance cases, Aid to Dependent Children cases and Blind Assistance cases whose payment is due and remains unpaid as of the tenth day of each month immediately after said date, and Party of the First Part shall pay in one payment to said agent of the Second Party on or before the tenth day of each month succeeding a sum equal to Three Dollars (\$3.00) per grant for all assistance cases of all classes on the approved list of the Shawnee County Social Welfare Board who have not paid the preceding months payment directly to the Second Party's agent during the preceding month.

"Paragraph 4. FREE CHOICE OF PHYSICIANS.—It is mutually agreed by the parties hereto that all assistance cases, persons or patients effected by the provisions hereof shall have a free choice of physicians participating herein and in accordance with Section 5 of this agreement.

"Paragraph 5. SERVICE AS COUNTY PHYSICIAN.—That in consideration of said employment and the payment of the stated compensation, Party of the Second Part agrees to furnish ordinary and reasonable medical and surgical care compatible with the standards and ethics established by the profession and within the ability and scope of the participating physicians and within the customary and usual practice of the physicians participating in this agreement whereby the well being of patients is assured by providing them with the best possible medical care including ordinary and reasonable hospitalization, drugs and medicines, and specialized services, when such are approved by Party of the Second Part and when such drugs and medicines are included in a prescription issued to patients by participating attending physicians. It is understood, however, that the services above mentioned include only those which are deemed to be essential to the needs and welfare of patients and which are approved by Party of the Second Part.

"LIKEWISE: that the following services are not included therein: surgery and treatment not within the customary and usual practice of the Party of the Second Part's participating physicians; surgery and

treatment for which necessary equipment, facilities or incidentals are not available or provided; dentistry, nursing; appliances including eye glasses, and services available thru other agencies. Party of the Second Part also reserves the right to require ambulatory patients to be treated and examined at designated times and places as is compatible with the circumstances of cases.

"Paragraph 8. TREATMENT OF NON-ASSISTANCE CASES.—That Party of the First Part will not be responsible for payments for services rendered persons or families not on County-approved Assistance list, or supplements thereto. Provided, however, that in emergency cases, for which, in the opinion of the Physicians' Committee, emergency treatment was necessary, and investigation by the County Director discloses that the case is eligible for assistance, Party of the First Part will pay for such emergency medical or surgical care, to the agent of Second Party, in lieu of the payments set out in Section 3 above, at the unit rate set out in the fee schedule hereto appended, and at the par value of One Dollar (\$1.00) per unit. Provided further, that if treatment is needed by other non-assistance cases, and cases defined above as emergency cases, for which continued medical care is required following the emergency care and which are approved as eligible for assistance by the County Director, such treatment will be furnished by Second Party upon such cases being placed on the assistance rolls. Said payments for both types of cases to be paid to agent of Second Party and not to any individual of Second Party. It is further agreed that no cases not otherwise approved for assistance will be approved by First Party for medical assistance only, except as provided in this paragraph.

"Paragraph 14. LIABILITIES.—It is specifically understood and agreed that the physicians participating in this agreement are not partners and that they do not, by the execution of this agreement assume any of the rights or liabilities incident to a partnership. It is further understood that each physician shall be solely responsible for his diagnosis and treatment of such patients as shall come under his care and shall not be held liable by any one for the negligence of any other subscribing physician, whether such negligence arises out of the treatment of patients pursuant to this contract or otherwise."

Several months prior to the signing of the contract, a Social Medicine Committee was appointed and given full power to act on all matters concerning the proposed plan. After the acceptance of the contract, five sub-committees were formed. The members of the social committee acting as chairmen of the Sub-Committees on Drugs and Supplies, Clinic, Hospital, Unit Audit and Appeals and Complaints.

The Sub-Committees handle various matters coming under their division as indicated. The General Social Medicine Committee meets regularly each week. This committee acts on recommendations of the sub-committees and executive secretary, establish policies and transact such other business as it deems necessary and advisable.

One of the early acts of the Social Medicine Committee was to send out a questionnaire to all members of the society requesting that they indicate their preference as to the capacity in which they wishes to serve. With one or two exceptions every member of the society responded. Working from this questionnaire, twenty eight members were assigned to home-call service, forty to the clinic staff and eleven for specialized services in their office or at hospitals. The Shawnee County Medical Society were particularly fortunate at this step of the organization as the city of Topeka turned over to the society all the facilities in their new modern and moderately equipped city clinic rooms. With these facilities the society was able to set up fourteen specialized clinics in addition to the general medical clinic which is held daily.

The specialized clinics are held once or twice each week and the entire staff is composed of forty doctors each one serving an average of two hours each week. In addition to the medical clinic the following Clinics are now in operation: Surgery, Gynecology, Eye, Ear, Nose and Throat, Pediatrics, Proctology, Tuberculosis, Child Welfare, Diabetic, Neuropsychiatry, Prenatal, Dermatology, Urology, Cardiology, and Venereal Disease.

As a general rule all ambulatory patients are required to report to the clinic for examination and treatment. When home calls are required the patients are allowed free choice among the twenty-eight physicians who have volunteered for this type of service. When surgery is required, the patient may also choose any surgeon in the society to perform such surgery as is required.

A dispensary is also maintained at the clinic where a druggist is employed by the society and fills the prescriptions during clinic hours. After clinic hours emergency prescriptions are either filled by the druggist authorized by the society or supplied by the attending physician from a kit issued by the dispensary. The average number of prescriptions issued in a month is around eighteen hundred.

The attendance at the clinic average about fourteen hundred monthly; five hundred and fifty home calls are made monthly and three hundred seventy-five patients are seen in the various offices; an average of thirty-four patients are admitted to the hos-

(Continued on Page 491)

President's Page

To the Members of The Kansas Medical Society:

As this is written, the recent favorable events in our war struggle bring us into the Christmas season with a feeling of thankfulness and optimism, and with the assurance that continued and unremitting effort will bring us final victory.

I would like at this time to personally pay the tribute of all the Kansas medical profession to the 425 members from our ranks who are serving in our armed forces in all parts of the world. The unselfish service and willing personal sacrifice of the doctors in service is deserving of the deepest appreciation not only of all of the medical profession but of the entire state. The doctors who remain on the home front owe unlimited labor in giving the best of medical care to the civil population during this period of emergency, and we must maintain the highest standards of medical care and practice that will make our members in the armed forces proud to come back to medical practice in Kansas after the war is over.

With a clear knowledge that work and strain and sacrifice lay ahead of all of us yet, may I wish to every member of The Kansas Medical Society, wherever he may be, a personally happy Christmas Season and all that is worth while for the year ahead.

Sincerely,

Henry N. Tichen, M. D.

President, The Kansas Medical Society.

EDITORIAL

KANSAS FIRST PHYSICIAN - CASUALTY

The first known Kansas medical corps casualty was listed in the November issue of the Journal. Dr. Raymond Cunningham Stiles, thirty years of age, in the medical corps of the United States Army was killed in a crash of a United States Army transport on September 3, near Coamo, Puerto Rico.

Dr. Stiles, originally a Wyandotte County resident, attended the University of Kansas, was graduated from Baylor University College of Medicine in 1937 and interned in St. Margaret's Hospital in Kansas City in 1938 at which time he was a member of The Kansas Medical Society and of the Wyandotte County Medical Society. Recently he was stationed in the United States Marine Hospital in Buffalo, New York and before that at Ft. Knox, Kentucky.

It is most interesting to note that in World War I the first medical corps casualty was Dr. William T. Fitzsimons of Kansas City, Missouri, who graduated from the University of Kansas School of Medicine in 1912, in whose honor the United States Army 1,185 bed hospital, the Fitzsimons Hospital of Denver, Colorado was named. In World War II the first medical corps casualty in the central states was again

a Kansas City physician but this time a member of The Kansas Medical Society.

KANSAS PHYSICIANS IN SERVICE

The Editorial Board is very happy and proud to publish in this, our Christmas issue of the Journal, the Kansas Military Honor list. More than 425 Kansas physicians, listed below are now serving in some un-named post, hospital, or on some ship or battle front, in the United States Army, Navy or Marine Corps.

Kansas can well be proud of her record of men in the medical corps and their number ranks high in comparison with other states in the total list of licensees.

The central office and the Journal staff have been attempting to compile a military service list for the past several months, and in so far as it is possible we believe this list is accurate. However, it will be necessary to add to and to revise the list constantly due to changes in rank and other information received in the central office. The non-members are starred and as will be noted many of these have gone directly into the service from an internship. Due to censor requirements no service address can be given, and in so far as possible the men are listed at their last known Kansas address.

The Kansas Military Honor Roll follows:

KANSAS MILITARY HONOR ROLL

ALLEN COUNTY

Maxson, Theodore R.*—Iola, Captain.....Army
Nevitt, James R.—Moran, Captain.....Army
Robinson, Leo D.*—Iola, Lieutenant.....Army
Schmaus, Lyle F.—Iola, Captain.....Army

ANDERSON COUNTY

Spencer, Harold F.—Garnett, Lieutenant.....Navy
White, Ralph E.—Garnett, Lieutenant.....Army

ATCHISON COUNTY

Bosse, Frank K.—Atchison, Lieutenant.....Army
Brady, Charles S.—Atchison.....Army
Fast, William S.—Atchison, Lieutenant.....Army
Jeffries, Robert C.—Atchison, Lieutenant.....Navy
Morrison, Ira R.—Atchison, Captain.....Army
Wallace, Wayne O.—Atchison, Lieutenant.....Army
Wulff, Edwin T.—Atchison, Lieutenant.....Army

BARBER COUNTY

Dougan, A. F.—Kiowa.....Army
Gacusana, Jose M.—Sharon, Major.....Army
Grigsby, Kenneth R.—Medicine Lodge, Major.....Army
Turner, Ralph D.—Medicine Lodge.....Army

BARTON COUNTY

Carlson, Marlin W.—Ellinwood, Captain.....Army
Dillon, John A., Jr.—Great Bend, Captain.....Army

Gaume, James G.—Ellinwood, Lieutenant.....Army
Kendall, Donald A.—Great Bend, Captain.....Army
Leiker, Raymond J.—Great Bend, Captain.....Army
Roesler, Bruce E.*—Clafin, Lieutenant.....Army
Robinson, Corbin E.—Hoisington, Lieutenant.....Army
Wenke, Leo L.—Great Bend, Lieutenant.....Army

BOURBON COUNTY

Albright, Fred C.—Garland.....Army
Cooper, Lawrence L.—Fort Scott.....Army
Cushing, Robert L.*—Lieutenant.....Army
Irby, Pratt—Fort Scott, Captain.....Army
Randles, Leland P.—Fort Scott, Lieutenant.....Army
Stone, Francis M., Jr.*—Fort Scott.....Army
Young, Robert S.—Fort Scott, Lieutenant.....Army

BROWN COUNTY

Hinton, Elmer E.*—Hamlin, Lieutenant J. G.....Navy
Lawrence, Edward K.—Hiawatha, Lt. Col.....Army
Wyatt, Ralph M.—Hiawatha, Lieutenant.....Army

BUTLER COUNTY

Brian, Robert M.—ElDorado, Captain.....Army
Cloyes, Arthur P.—ElDorado, Captain.....Army
Johnson, Joseph H.—ElDorado, Captain.....Army
Metcalf, Ralph J.—ElDorado, Lt. Comdr.....Navy
Murray, Leo. C.—ElDorado, Captain.....Army
Steffen, Lawrence F.—ElDorado, Lieutenant.....Army

CHEROKEE COUNTY

Athy, Gregg B.—Columbus, Lieutenant.....Army
 Bux, Donald E.—Columbus, Lieutenant.....Army
 Martin, Oliver L.—Baxter Springs, Lieutenant.....Army

CLAY COUNTY

Anderson, Severt A.—Clay Center, Lieutenant.....Navy
 Garrett, Glen R.*—Clay Center, Lieutenant.....Army
 Klauman, Benjamin F.*—Clay Center, Lieutenant.....Army

CLOUD COUNTY

Kiene, Richard H.—Concordia.....Navy
 Kosar, Clarence D.—Concordia, Captain.....Army
 Porter, John M.—Concordia, Lt. Comdr.....Navy
 Robertson, Howard T.*—Concordia.....Army

COFFEY COUNTY

Hunter, Kenneth R.—Lebo, Lieutenant.....Army

COMANCHE COUNTY

Howard, Donald O.—Protection, Lieutenant.....Army

COWLEY COUNTY

Brown, Harwin J.—Winfield, Captain.....Army
 Cummins, Walter J.—Winfield, Lieutenant, J. G.....Navy
 Grosjean, Wendell A.—Winfield, Captain.....Army
 Hall, Frederick W.—Winfield, Lieutenant.....Army
 Moran, Charles T.—Arkansas City, Captain.....Army
 Norris, George L.—Winfield, Lieutenant.....Army
 Snyder, Howard E.—Winfield, Major.....Army
 Ward, Delbert A.—Arkansas City, Lt. Comdr.....Navy
 Weston, William G.—Arkansas City, Captain.....Army

CRAWFORD COUNTY

Bell, Cleo D.—Pittsburg, Captain.....Army
 Bena, James H.—Pittsburg, Lieutenant.....Army
 Erickson, Clarence W.—Pittsburg, Lieutenant.....Army
 Haigler, James P.*—Pittsburg.....Army
 Haigler, Frederick H.—Cherokee, Lieutenant.....Army
 Mollahan, Morgan L.—Arcadia, Lieutenant.....Army
 Newman, Clifford B.—Pittsburg, Captain.....Army
 Parrish, William A.—Pittsburg, Major.....Army
 Revell, Arthur J.—Pittsburg, Captain.....Army
 Schulte, Edward J.—Girard, Captain.....Army
 Veatch, Harry J.—Pittsburg, Captain.....Army
 Wood, Douglas H.—Pittsburg, Lieutenant.....Army

DICKINSON COUNTY

Conklin, Kenneth E.—Abilene, Captain.....Army
 Danielson, Arthur D.—Herington, Lieutenant.....Navy

DONIPHAN COUNTY

Motherhead, John L.—Denton, Lieutenant.....Army
 Swails, John G.—Wathena, Lieutenant.....Army

DOUGLAS COUNTY

Anderson, Arthur S.—Lawrence, Major.....Army
 Auchard, Virgil M.—Lawrence, Major.....Army
 Brooks, Dean*—Lawrence.....Army
 Dunlap, Richard L.—Lawrence, Lieutenant.....Army
 Enders, Edwin Wray—Lawrence, Captain.....Army
 Hood, Thomas R.—Lawrence.....Army
 Jones, Hiram P.—Lawrence, Captain.....Army
 Mott, James M.—Lawrence, Captain.....Army
 Nelson, Dick*—Lawrence.....Navy
 Powell, Lyle S.—Lawrence, Colonel.....Army
 Renick, Fred T.—Lawrence, Captain.....Army
 Schwegler, Raymond A.—Lawrence, Captain.....Army
 Vetter, Ronald C.*—Lawrence.....Army
 Walters, Byron*—Lawrence.....Army

ELLIS COUNTY

Brewer, William M.—Hays, Major.....Army

ELLSWORTH COUNTY

Horejsi, Alfred J.—Ellsworth, Lieutenant.....Army

FINNEY COUNTY

Lewis, George Kenneth—Garden City—Major.....Army
 Maxfield, Russell J.*—Garden City, Lieutenant, J.G.....Navy
 Sartorius, Herman C.—Garden City, Captain.....Army

FORD COUNTY

Alderson, Clair M.—Dodge City.....Army
 Davis, Donald—Dodge City.....Army
 Dennis, Foster L.—Dodge City, Major.....Army
 Mandeville, George—Dodge City, Major.....Army
 Speirs, Richard E.—Dodge City, Major.....Army

FRANKLIN COUNTY

Badger, Edward B.*—Ottawa, Captain.....Army
 Barr, John F.—Ottawa, Lt. Comdr.....Navy
 Davis, George W., Jr.—Ottawa, Lieutenant, J.G.....Navy
 Henning, Colvin W.—Ottawa, Captain.....Army
 Henning, Joseph R.—Ottawa, Captain.....Army
 Kaiser, Max E.—Ottawa, Lieutenant.....Army
 Wallen, James E.—Ottawa.....Navy

GEARY COUNTY

Brethour, Leslie J.—Junction City, Lieutenant.....Army
 Carr, Robert M.—Junction City, Lieutenant.....Navy
 Filkin, Lawrence E.—Junction City, Lieutenant.....Army
 Gold, David*—Lieutenant.....Army
 Lanning, Robert J.—Junction City, Captain.....Army
 Smiley, Edward A.—Junction City, Lieutenant.....Army

GRAHAM COUNTY

Vesper, Vernon A.—Hill City, Captain.....Army

GREELEY COUNTY

Wilson, Donald J.—Tribune, Lieutenant.....Army

GREENWOOD COUNTY

Baird, Cecil D.—Eureka, Captain.....Army
 Basham, Charles E.—Eureka, Captain.....Army
 Fairbrother, William C.—Madison, Captain.....Army

HARPER COUNTY

Pokorney, Charles—Attica.....Army

HARVEY COUNTY

Gleason, Kenneth J.—Newton, Captain.....Army
 Gradinger, Billens C.—Halstead, Lieutenant.....Army
 Grove, John A.—Newton, Captain.....Army
 Grove, William E.—Newton, Lieutenant.....Army
 Hawkey, Alfred S.—Newton, Lieutenant.....Navy
 Hertzler, John W.—Newton, Lieutenant.....Navy
 Kamish, Robert J.*—Halstead, Captain.....Army
 Martin, Melvin C.—Newton, Captain.....Army
 Munsell, D. W.*—Halstead.....Navy
 Poling, Fowler B.*—Halstead, Lieutenant.....Army
 Rost, Glenn S.*—Halstead, Captain.....Army
 Schmidt, C. Robert*—Halstead, Lieutenant.....Army
 Sills, Charles T.—Newton, Lieutenant.....Army
 Street, Glenn*—Halstead, Lieutenant.....Army
 Walsh, William S.—Halstead, Lieutenant.....Army

JACKSON COUNTY

Condon, Albert Paul—Whiting, Lieutenant.....Army
 Moser, Ernest C.—Holton, Lieutenant.....Army
 Wyatt, Charles A.—Holton, Major.....Army

JEFFERSON COUNTY

Bowen, Clovis W.—Valley Falls, LieutenantArmy
 Martin, Earl A.—Oskaloosa.....Army

JEWELL COUNTY

Turner, Robert C.*—Mankato, Lieutenant, J.G.....Navy

JOHNSON COUNTY

Becker, Richard R.—Kansas City, Captain.....Army
 Beebe, Edmer—Olathe, Captain.....Army
 Carbaugh, Kenneth W.—Mission, Captain.....Army
 Grayson, Roy David—Overland Park, Major.....Army
 McFarland, McDonald—Kansas City, Major.....Army
 Maser, George R.—Overland Park, Lieutenant.....Air Corps
 Reece, Adelbert S.—Gardner, Captain.....Army
 Tolle, Cecil F.*—Overland Park, Major.....Army
 Weaver, James B.—Kansas City, Lt. Col.....Army

KINGMAN COUNTY

Baldrige, Richard E.—Kingman, Lieutenant.....Army
 Eggleston, Donald E.—Kingman, Lieutenant.....Army
 McCarty, Dale C.—Nashville.....Army
 Knappenberger, Roy C.*—Penalosa.....Army
 Waylan, Thornton Lewis—Nashville, Lieutenant.....Army

KIOWA COUNTY

Wilson, William Errol—Greensburg, Captain.....Army

LABETTE COUNTY

Baird, Albert C.—Parsons, Captain.....Army
 Carter, Percy C.*—Parsons.....Army
 Cramer, Guy W.—Parsons, Lieutenant.....Army
 Donnelly, Bernard A.*—Parsons, Lieutenant.....Army
 Rose, Ralph J.—Parsons, Lieutenant.....Army

LEAVENWORTH COUNTY

Epstein, Joseph G.*—Wadsworth, Captain.....Army
 Gier, Jacob B.*—Wadsworth, Lieutenant.....Army
 Gonser, Karl B.*—Leavenworth.....Army
 Moore, Robert H.—Lansing, Lieutenant.....Army
 Sereres, Edgar P.*—Kansas City.....Army
 Thomas, William M.—Leavenworth, Captain.....Army
 Watkins, Lucien A.—Leavenworth, Lieutenant.....Army

LINCOLN COUNTY

Anderson, Paul S.—Sylvan Grove, Lieutenant.....Army
 Songer, Herbert Lee—Lincoln, Lieutenant.....Army

LINN COUNTY

Lee, Carleton H.—Pleasanton.....Army

LYON COUNTY

Davis, David R.—Emporia, Lt. Comdr.....Navy
 Eckdall, Funston J.—Emporia, Captain.....Army
 Harvey, Clarence C.*—....., Lt. Col.....Army
 Kerr, Samuel E.*—Emporia, Lieutenant.....Army
 Morgan, John L.*—Emporia, Lieutenant.....Army
 Neinstedt, John F.—Hartford, Lieutenant.....Army
 Underwood, Charles C.—Emporia, Lieutenant.....Army

MARION COUNTY

Siebert, Norman C.*—Canada, Lieutenant.....Army
 Thomas, Theodore J.—Florence.....Army
 Unruh, Rudolph T.—Goessel, Captain.....Army

MARSHALL COUNTY

Bolton, Dan W.—Frankfort, Captain.....Army
 Diefendorf, Donald M.—Waterville, Captain.....Army
 Lafene, Benjamin Wm.—Marysville, Captain.....Army

MC PHERSON COUNTY

Finkle, Guy E.—McPherson, Lieutenant.....Army
 Lewis, Letteer—McPherson, Lieutenant.....Army
 Sohlberg, Robert Jr.—McPherson, Captain.....Army

MEAD COUNTY

Wakeman, Everal M.*—Fowler, Lieutenant.....Army

MIAMI COUNTY

Aldis, John—Osawatomie, Lieutenant.....Army
 Brown, William—Paola, Captain.....Army
 Fowler, James T.—Osawatomie, Lieutenant.....Army
 Roach, Harry M.—Osawatomie, Lieutenant.....Army

MITCHELL COUNTY

Bennett, Richmond E.—Beloit.....Army
 Jordan, Ralph E.*—Beloit, Lieutenant.....Army

MONTGOMERY COUNTY

Craig, Paul E.—Coffeyville.....Army
 Ellis, Stephen S.—Coffeyville, Lieutenant.....Army
 Stensaas, Carl O.—Lindsborg, Lieutenant.....Army

NEMAHA COUNTY

Brown, Virgil E.—Sabetha, Lieutenant.....Army
 Rucker, Martin J.—Sabetha, Lieutenant.....Army

NEOSHO COUNTY

Ashley, George L.—Chanute, Lieutenant.....Army
 Cone, Luther H.—Chanute, Lieutenant.....Army
 Edwards, James F.—Chanute, Lieutenant.....Army

NORTON COUNTY

Evans, Arthur W.—Norton, Lieutenant.....Army
 Petterson, Cecil E.—Norton, Lieutenant.....Air Corps
 Stone, William F., Jr.—Norton.....Navy

OSAGE COUNTY

Lyter, Clinton S.*—Carbondale, Major.....Army
 McClintock, Edward A.*—Overbrook, Captain.....Army

OTTAWA COUNTY

Foutz, Homer S.—Minneapolis, Captain.....Army

PAWNEE COUNTY

Coughlin, Samuel T.—Larned, Captain.....Army
 Davis, Paul E.—Larned, Captain.....Army
 Hyde, Marshall E.—Larned, Captain.....Army

PRATT COUNTY

Christmann, Marshall E.—Pratt, Lieutenant.....Army
 Haworth, Kenneth W.—Pratt, Captain.....Army
 Thorpe, Francis A.—Pratt, Lieutenant.....Air Corps

RENO COUNTY

Armitage, Albert C.—Hutchinson, Captain.....Army
 Barnes, Harold R.—Hutchinson, Captain.....Army
 Blank, John N.—Buhler, Lieutenant.....Army
 Chickering, George A.—Hutchinson, Captain.....Army
 Franklin, Glenn C.*—Hutchinson, Lieutenant.....Army
 Fernie, Robert W.—Hutchinson, Lieutenant.....Navy
 Hill, James N.—Hutchinson.....Army
 Pinsker, Jacob A.—Hutchinson, Captain.....Army
 Scales, William M.—Hutchinson, Major.....Army
 Simpson, Ronald A.*—Hutchinson, Lieutenant.....Army
 Stone, Gordon E.—Hutchinson, Lieutenant.....Army

REPUBLIC COUNTY

Splichal, William F.—Bellevue.....Navy

RICE COUNTY

Beauchamp, Preston E.—Sterling, Captain.....	Army
Bula, Ralph E.—Lyons, Lieutenant.....	Army
Hill, Edwin R.—Lyons, Captain.....	Army
Marr, J. T.—Sterling.....	Army
Patterson, Harold L.—Bushton, Lieutenant.....	Army
Sprong, A. A.—Sterling, Lieutenant.....	Army

RILEY COUNTY

Ball, Ralph G.—Manhattan, Major.....	Army
Balding, Laurence G.—Manhattan, Captain.....	Army
Evans, Darrel Lee—Manhattan, Captain.....	Army
Hauckenberg, Everett*—Manhattan, Captain.....	Army
Horton, Robert John M.*—Manhattan, Lieutenant.....	Army
Hughes, Raymond H.—Manhattan, Lieutenant.....	Army
Kemphorne, Charles R.—Manhattan, Captain.....	Army
Marker, Daniel I.—Manhattan, Major.....	Army
Schwartz, Willard C.—Manhattan, Major.....	Army
Woods, Walton C.—Manhattan.....	Navy

RUSH COUNTY

Baker, Joseph H.*—LaCrosse, Captain.....	Army
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SALINE COUNTY

Anderson, Donald A.—Salina.....	Navy
Armstrong, Carroll W.—Salina, Lieutenant.....	Army
Cheney, Ralph E.—Salina, Major.....	Army
Eaton, Leslie F.—Salina, Lieutenant.....	Army
Harvey, Ernest E.—Salina, Lieutenant.....	Army
Simpson, James C.—Salina, Lieutenant.....	Army
Snyder, Maurice—Salina, Captain.....	Army
Stafford, George E.—Salina, Lieutenant.....	Army

SEDGWICK COUNTY

Adams, Austin J.—Wichita, Lieutenant.....	Navy
Anderson, Harry O.—Wichita, Lieutenant.....	Army
Bartlett, Wayne C.—Wichita, Major.....	Army
Blacker, Morris R.—Wichita, Captain.....	Army
Clapp, Raymond C., Jr.—Wichita, Lieutenant.....	Army
Coffman, Delphos Otto—Wichita, Lieutenant J.G.....	Navy
Donnell, Louis A.—Wichita, Lieutenant.....	Navy
Drake, Ralph L.—Wichita, Major.....	Army
Epp, Frederick O.*—Wichita, Lieutenant.....	Army
Fisher, James B.—Wichita, Captain.....	Army
Forman, Louis, H.*—Wichita, Captain.....	Army
Frey, Charles T.*—Wichita, Lieutenant.....	Army
Gsell, George F.—Wichita, Captain.....	Army
Hall, Millard W.—Wichita, Major.....	Army
Hamilton, Oscar A., Jr.*—Wichita, Lieutenant.....	Army
Hibbard, James S.—Wichita, Lt. Comdr.....	Navy
Herbst, Robert Rudolph*—Wichita, Lieutenant, J.G.....	Navy
Hurst, Thomas C.—Wichita, Lieutenant.....	Army
Hyndman, Henry Harold—Wichita, Lieutenant.....	Army
Kaufman, LeRoy V.*—Wichita, Lieutenant.....	Army
Kiser, Willard J.—Wichita, Major.....	Army
Knapp, Leslie E.—Wichita, Major.....	Army
MacLeod, Sherburn—Wichita, Lieutenant.....	Navy
Magee, Charles R.*—Wichita, Lieutenant.....	Army
Matassarini, Frederick W.—Wichita, Major.....	Army
Mermis, William Leo—Wichita, Captain.....	Army
Miller, Clyde W.—Wichita, Lieutenant.....	Army
Mills, Earl L.—Wichita, Major.....	Army
Needles, Orval Thomas—Wichita, Captain.....	Army
O'Donnell, Harold F.—Wichita, Lt. Comdr.....	Navy
Palmer, Harold W.—Wichita, Major.....	Army
Prochazka, Otto F.—Wichita, Captain.....	Army
Putnam, Lyle B.—Wichita, Lieutenant.....	Army
Reed, Darwin C.*—Wichita, Lieutenant.....	Army

Reitz, Harvey E.—Wichita, Lieutenant.....	Navy
Rhoades, Gordon H.*—Wichita, Lieutenant.....	Army
Ross, Earl B.—Wichita, Lt. Col.....	Army
Rossitto, A. F.—Wichita, Captain.....	Army
Stratemeier, Edward H.*—Wichita, Lieutenant.....	Army
Stout, Samuel L.—Wichita, Lieutenant.....	Army
Scuka, Clayton L.*—Wichita, Lieutenant.....	Army
Thorpe, George L.—Wichita, Captain.....	Air Corps
Warfield, Chester H.—Wichita, Lt. Comdr.....	Navy
Wier, Charles K.—Wichita, Lt. Comdr.....	Navy
Williams, Harold O.—Cheney, Captain.....	Army
Young, Paul B.—Wichita, Lieutenant.....	Army

SEWARD COUNTY

Zimmermann, Leon W.—Liberal, Lieutenant.....	Army
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SHAWNEE COUNTY

Anderson, Robert C.—Topeka, Captain.....	Air Corps
Ashley, Byron J.—Topeka, Lt. Comdr.....	Navy
Beller, Willis L.*—Topeka, Lieutenant.....	Army
Beach, George C., Jr.*—Topeka, Lt. Col.....	Army
Blake, Henry S.—Topeka, Lieutenant.....	Marines
Bowen, James S.—Topeka, Lieutenant.....	Army
Bowen, Harry J., Jr.—Topeka, Lieutenant.....	Army
Boyd, Spencer H.—Topeka, Lieutenant.....	Army
Carlin, Karl A.*—Topeka, Lieutenant.....	Army
Clark, Orville R.—Topeka, Major.....	Army
Crank, Henry Harlan—Topeka, Lieutenant.....	Navy
Eckles, Lucius E.—Topeka, Lt. Comdr.....	Navy
Finney, Guy A.—Topeka, Major.....	Army
Ford, Frederick L.—Topeka, Lieutenant.....	Army
Gale, Norman A.*—Topeka.....	Army
Gorman, R. B.—Topeka, Lieutenant.....	Army
Graber, Harold L.*—Topeka, Lieutenant.....	Army
Gray, David E.*—Topeka, Lieutenant.....	Army
Greenewood, Edward D.—Topeka, Captain.....	Army
Hammel, Seth A.—Topeka, Lt. Col.....	Army
Helwig, George F.—Topeka, Lieutenant.....	Navy
Hunter, J. Theron—Topeka, Lt. Comdr.....	Navy
Joss, Charles*—Topeka, Lieutenant.....	Army
Kirkpatrick, Hazen L.—Topeka, Captain.....	Air Corps
Krehbiel, B. I.—Topeka, Lt. Comdr.....	Navy
Menninger, William C.—Topeka, Lt. Col.....	Army
Powers, Harold W.—Topeka, Major.....	Army
Pusitz, Manuel E.—Topeka, Major.....	Army
Pyle, Lucien R.—Topeka, Lt. Comdr.....	Navy
Raines, Omer M.—Topeka, Captain.....	Army
Riedel, Robert H.—Topeka, Captain.....	Army
Robbins, Louis L.—Topeka, Lieutenant.....	Army
Saylor, Leslie L.—Topeka, Lieutenant.....	Army
Saxe, Earl—Topeka, Captain.....	Army
Sellards, Howard E.*—Topeka, Lieutenant.....	Army
Schwartz, Lloyd E.*—Topeka, Lieutenant.....	Army
Scott, William B.—Topeka, Captain.....	Army
Stone, Mark L.*—Topeka, Lieutenant.....	Army
Swan, Otis Dwight*—Topeka, Lieutenant.....	Army
Taggart, Floyd C.—Topeka, Captain.....	Army
Tillman, Carl D.—Topeka, Lieutenant.....	Navy
Wakeman, Don C.—Topeka, Captain.....	Army
Zagaría, James F.*—Topeka, Lieutenant.....	Army

SMITH COUNTY

Sekavec, Gordon B.*—Athol, Lieutenant.....	Army
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STAFFORD COUNTY

Fritzmeier, William*—Stafford, Lieutenant.....	Army
Graves, Louis G.—St. John, Lieutenant.....	Army

SUMNER COUNTY

Buoa, Fern W.—Mulvane, Captain.....Army
 Cole, Ward M.—Wellington, Lieutenant.....Army
 Dewey, Charles H.—Wellington, Major.....Army
 Evans, Ferris, D.—Conway Springs, Lieutenant.....Army
 Howell, J. Allen—Wellington, Lieutenant.....Army
 VanDeventer, Roy W.—Wellington, Major.....Army
 Voldeng, Karl E.—Wellington, Captain.....Army

TREGO COUNTY

Long, Gerald A.*—....., Captain.....Army

WABAUNSEE COUNTY

Walker, William H.*—Eskridge, Lieutenant.....Army

WASHINGTON COUNTY

Eckart, DeMerle E.*—Linn, Lieutenant, J.G.....Navy
 Tooley, George E.—.....Marines
 McConchie, James E.*—Washington, Lieutenant.....Army

WILSON COUNTY

Beal, Lynn E.—Fredonia, Lieutenant.....Navy
 Beal, Raymond J.*—Fredonia, Lieutenant.....Army
 Meisburger, Richard G.—Fredonia.....Navy
 Moorehead, Frank A.—Neodesha, Lieutenant.....Army
 Rich, William T.—Neodesha, Lieutenant.....Navy
 Stotts, Charles S.—Fredonia, Lieutenant.....Army

WOODSON COUNTY

Lee, George R.—Yates Center, Captain.....Army

WYANDOTTE COUNTY

Abrams, William W.—Kansas City, Captain.....Army
 Algie, William H.—Kansas City.....Navy
 Allen, Max S.—Kansas City, Lieutenant.....Army
 Angle, Lewis W.—Kansas City, Lt. Comdr.....Navy
 Barry, William B.—Kansas City, Captain.....Army
 Belot, Monte L., Jr.—Kansas City, Lieutenant.....Army
 Bernreiter, Michael—Kansas City.....Army
 Betz, John S.—Kansas City, Lieutenant.....Army
 Bowser, John F.—Kansas City, Captain.....Army
 Campbell, James W.*—Kansas City, Lieutenant.....Army
 Carmichael, F. W., Jr.*—Kansas City, Captain.....Army
 Cziraky, Anton—Kansas City, Lieutenant.....Army
 Davis, C. G.—Kansas City, Lieutenant.....Army
 Delp, Mahlon H.—Kansas City, Major.....Army
 Dillon, Tony G.—Kansas City, Major.....Army
 Evans, Joseph G.—Kansas City, Lieutenant.....Army
 Floersch, Hubert M.—Kansas City, Lieutenant.....Army
 Goldblatt, Bernard—Kansas City, Captain.....Army
 Grosdidier, Edward J.—Kansas City, Captain.....Army
 Grippy, Clarence—Kansas City, Lieutenant, J.G.....Navy
 Hamilton, Tom: Reid—Kansas City, Captain.....Army
 Helwig, Ferdinand C.*—Kansas City.....Navy
 Henry, Schubert David—Kansas City, Captain.....Army
 Harless, Marris S.—Kansas City, Captain.....Army
 Hiebert, Peter E.—Kansas City, Major.....Army
 Hinshaw, Alfred H.—Kansas City, Captain.....Army
 Knight, Durell K.—Kansas City, Captain.....Army
 Laing, Maurice V.—Kansas City, Captain.....Army
 Lee, Robert L.—Kansas City, Captain.....Army
 Leger, Lee H.—Kansas City, Major.....Army
 Luke, John H.—Kansas City, Captain.....Army
 McKee, Leo F.*—Kansas City, Lieutenant.....Army
 Manley, J. Warren—Kansas City, Lieutenant.....Army
 May, James W.—Kansas City.....Navy
 Mullen, Clifford J.—Kansas City, Major.....Army
 Neas, Ingall H.—Kansas City, Lieutenant.....Army

Neighbor, Ernest G.—Kansas City, Lieutenant.....Army
 Newman, Robert L.*—Kansas City, Lieutenant.....Army
 Nothnagel, Arnold F.*—Kansas City, Lieutenant.....Army
 Ortman, Garth S.—Kansas City, Lieutenant.....Army
 Rabe, Melvin A.*—Kansas City, Lieutenant.....Army
 Reed, H. Lester*—Kansas City, Lieutenant.....Army
 Reeves, Eugene A.—Kansas City, Lieutenant.....Army
 Richardson, Lyman K.*—Kansas City, Captain.....Army
 Richeson, Rae Arthur—Kansas City, Captain.....Army
 Rook, Lee Emerson—Kansas City, Captain.....Army
 Rummold, M. J.—Kansas City, Major.....Army
 Ryan, Maurice J.—Kansas City, Lieutenant, J.G.....Navy
 Ryan, Michael J.*—Kansas City, Lieutenant.....Army
 Samuelson, Edward A.—Kansas City.....Army
 Schiffmacher, Jack E.*—Kansas City, Lieutenant, J.G. Navy
 Schulte, Emmerich—Kansas City, Captain.....Army
 Shanklin, John H.*—Kansas City, Lieutenant.....Army
 Sims, Thomas J., Jr.—Kansas City, Major.....Army
 Sophian, Abraham, Jr.*—Kansas City, Lieutenant.....Army
 Speer, Frederick A.—Kansas City, Lieutenant.....Navy
 Speer, Leland N.—Kansas City, Lieutenant.....Navy
 Stauffer, Maurice H.*—Kansas City, Lieutenant.....Navy
 Steinzeig, Alfred S.—Kansas City, Lieutenant.....Army
 Stiles, Raymond C. (Deceased)—Kan. City, Captain Army
 Voorhees, Gordon S.*—Leavenworth, Lieutenant.....Army
 Walker, Maurice A.—Kansas City, Major.....Army
 Weber, Clarence J.—Kansas City.....Army
 Wilson, Robert B.—Kansas City.....Army
 Young, Chester Lee—Kansas City, Lieutenant.....Army

SHAWNEE COUNTY MEDICAL CARE PLAN

(Continued from Page 485)

pital each month; average time in which these patients are in the hospital is approximately fourteen days.

After all funds from all sources have been received, for any given month, all bills are paid first; a small reserve set aside and the balance is then distributed to the individual participating member on a unit basis in accordance with an established fee schedule for services rendered.

Space will not permit further detail of the various activities. However, under this set-up the members are able to give the patients far better service than this class of people have received in the past. Since this work is co-ordinated the profession is able to do this more efficiently and with less effort for the same results. They have also been able to receive some small compensation for their efforts and a small reserve to tide them over in case of emergency. While the fine co-operation of the Shawnee County Welfare Department made the establishment and continuation of the plan possible, the major credit for the successful operation belongs to the Social Medicine Committee who established the policies, and the fine co-operation of the individual members, all of whom have donated liberally of their time and services.

TUBERCULOSIS CONTROL

UNDIAGNOSED TUBERCULOSIS IN ELDERLY PERSONS

Tuberculosis has been commonly considered a disease of youth. Its largest number of victims are post-adolescents and those of early middle life when super-infections most often occur. Many there are, however, who do not succumb to the disease nor yet eliminate the infection. As hosts to the tubercle bacillus they carry on an adjusted symbiotic existence which may reach into a green old age. The chronic cough attributed to "asthma" or "bronchitis" may actually be due to an indolent tuberculous process often accompanied by bacillary sputum. The menace of such occult cases to family and friends is obvious.

The detection of these cases is among the more baffling problems of a control program since experience has shown that it is difficult to obtain the examination of the elderly spreaders. They are naturally skeptical of the idea that they may be infected and often refuse examination through apathy or through fear that something may be found that would alter their customary manner of life. Commissioner Godfrey in a study of seventeen counties in up-state New York found that in the cases studied forty-three per cent of the contacts under forty were examined, against only fourteen per cent of those contacts who were above that age.

"The best method of finding the elderly spreader of tuberculosis would seem to be the mass x-ray

survey. Up to the present time, however, this method has not been used widely. Bloch has estimated that more than half the reports published on surveys in adults concern themselves with university students, hospital personnel and student nurses. The majority of other surveys have been made on industrial and racial groups containing only a relatively small percentage of persons above the age of forty.

"Despite the fact that he is seldom discovered by any of the aforementioned methods of case finding, the relative frequency with which the elderly phthisic occurs in the population should make him of the greatest concern to those interested in tuberculosis control. Mortality figures for the United States, as prepared by Dublin, show that the highest death rate from tuberculosis occurs in males from sixty-five to seventy-four years of age, and in females seventy-five and over. Mortality statistics for New York City, prepared by Drolet, illustrate the fact that the decline in tuberculosis mortality since 1920 has been much greater in the young than in the old, particularly in males. The phenomenal decrease in tuberculosis among younger persons of New York City during this twenty-year period may very well reflect the efficiency of the methods used for its prevention, detection and treatment, while the high mortality of the elderly may partially be due to the fact that the same degree of emphasis has not been placed on the control of tuberculosis in this group."

At the Kips Bay-Yorkville Chest Clinic (New York City) a mass x-ray survey was made of 3,414 apparently healthy persons on home relief. The following table shows that the percentage of tuberculosis proved to be highest among those above forty years of age.

AGE AND SEX DISTRIBUTION OF CHRONIC AND SIGNIFICANT PULMONARY TUBERCULOSIS

AGE GROUP	MALES					FEMALES				
	Number examined	Chronic pulmonary tuberculosis	Per Cent	Significant pulmonary tuberculosis	Per Cent	Number examined	Chronic pulmonary tuberculosis	Per Cent	Significant pulmonary tuberculosis	Per Cent
15-19.9	133	0		0		134	0		0	
20-29.9	74	2	2.70	2	2.70	161	1	0.62	0	
30-39.9	192	11	5.73	5	2.60	314	9	2.87	5	1.59
40-49.9	257	30	11.67	17	6.61	347	17	4.90	6	1.73
50-59.9	365	44	12.05	22	6.03	418	35	8.37	10	2.39
60-69.9	350	50	14.29	17	4.86	450	49	10.89	8	1.78
70-79.9	166	20	17.24	5	4.31	84	9	10.71	3	3.57
80-84.9	9	2	22.22	0		10	2	20.00	0	
Total	1,496	159	10.63	68	4.55	1,918	122	6.36	32	1.67
Under 40	399	13	3.26	7	1.75	609	10	1.64	5	0.82
Over 40	1,097	146	13.31	61	5.56	1,309	112	8.56	27	2.06

Of the 100 clinically significant cases, twenty-nine have proved to be active on the basis of either (1) changes in the x-ray appearance of the lesions; either progressive or regressive, and (2) positive sputum.

Twelve of the positive-sputum cases found were over fifty years of age. None of these had marked symptoms at the time they were discovered and some have remained symptom free during a subsequent two years of observation. In such cases reactivation may await some new strain such as an extra physical load imposed on the worker who enters war industry. This is a risk for the healed or arrested case as well.

"It is not known whether the higher incidence of tuberculosis in the elderly which we have encountered in a group of unemployed also occurs in elderly persons of higher income levels. Since mortality tables are prepared from deaths at all strata, it would seem possible that this may be the actual state of affairs. In any event, it is of the utmost importance to devote a greater portion of our efforts in tuberculosis case-finding to the discovery of the elderly individual with tuberculosis. This should be done without lessening case-finding measures in young persons, as the latter comprise a larger proportion of the population. Consequently, although the percentage of tuberculosis may be less in those of younger years, the absolute number of cases undoubtedly is greater.

"More emphasis should be placed on the examination of all possible sources of a newly diagnosed case of tuberculosis. Even when the older members of a tuberculous household appear to be in the best of health, they should be x-rayed. When a thorough search of the immediate family of an affected person fails to reveal the source of infection, further inquiries should be made as to the identity of others with whom he has most frequent contact, and examination of these persons should be arranged.

"The physician should also always suspect tuberculosis in all his elderly patients who have even mild pulmonary symptoms, and should take the necessary steps to rule out this disease before making a final diagnosis.

"The most productive method of case finding among the elderly would seem to be the x-ray survey of such population groups. The survey detailed in this paper serves to illustrate the value of such a procedure. Similar surveys concentrated on the older fraction of the population, particularly males, would, we believe, disclose many unknown spreaders of tuberculosis who have been acting as reservoirs of disease in their communities."—From *Tuberculosis Abstract*, November, 1942. *Undiagnosed Pulmonary Tuberculosis in Elderly Persons*, Raymond E. Miller and Beatrice Henderson, *Am. Rev. Tuber.*, Aug. 1942.

NEWS NOTES

CONFERENCE OF SECRETARIES AND EDITORS

The featured speakers at the meeting in Chicago in November 20 were General Fred W. Rankin, President of the American Medical Association, Ross T. McIntire, Surgeon General of the Navy, Dr. Frank H. Lahey, Chairman of the Board of the Procurement and Assignment Service, General Hillman of the Office of the Surgeon General of the Army, Dr. Thomas Parran, Surgeon General of the Public Health Service and Colonel L. G. Rowntree, Chief of the Medical Division of the Selective Service System.

As these men are all eminently qualified to speak authoritatively in their respective departments it was a privilege to hear them discuss various phases of the war effort.

In discussing the future of medical meetings during the war in view of the limitations of transportation, civilian physician shortage, Dr. Rankin said a reduction in the number of meetings is necessary. He felt that multiple small meetings might be held and that post graduate assemblies of a regional nature should be retained. He suggested that the possibility of holding joint state meetings in some areas should be explored. The difficulty of securing programs will be a determining factor in limiting the number of meetings held but meetings on a national scale are out.

Dr. Lahey reiterated his previous promise that states which are over their quotas in 1942 will receive credit in their physician quota for 1943. Both he and Dr. Rankin feel the big job next year will be in providing doctors for civilian needs and industry. If this is to be done obstructions by state licensing boards must cease for the duration so that physicians available can be relocated according to need.

General Hillman said that we now have 36,000 physicians under orders which is 5,000 more than the total medical personnel in World War I. He believed that the army requirements in 1943 will be 1,000 new physicians per month.

Dr. Parran discussed in a thorough manner the problems created by population migration and unequal distribution of physicians which has always been partly on an economic basis and partly on a geographical one. He feels very properly that this problem needs some direction and much team work utilizing procurement and assignment service units, state licensing boards, industry, state boards of health, medical organization and the United States Public Health Service. At present he does not favor a special law to apply to doctors making all subject to orders. The whole problem can be better visualized when we know that 5,700,000 people have migrated and are now relocated in some community that may not have had any surplus of physicians before. In some instances Reserve Officers of the Public Health Service have been sent into scantily manned areas.

Surgeon General McIntire of the Navy gave a most hopeful note to the conference by reporting statistics from the Pacific area. The mortality of the first thousand wounded men transported by air to a base hospital for treatment was one per cent, being an all time low.

INDUSTRIAL HEALTH CONGRESS

The Fifth Annual Congress on Industrial Health sponsored by the Council on Industrial Health of the American Medical Association will be held on January 11-13, 1943 in Chicago at the Palmer House.

The increased need for industrial health services and the great demand for physicians and technicians necessary for this coverage has necessitated an intensified organization for the certification and training of physicians essential to industry. Plans along these lines will be discussed at the congress, along with a description of activities currently under way in production organizations in more than sixteen hundred plants, at the request of the War Production Board.

Subjects which will be covered either in symposium or by speakers are briefly as follows: infection in industry, the loss of time in industry in regard to health problem, the change in industrial personnel due to the war situation, industrial medicine and emergency problems, medical relations in Workmen's Compensation, medical records in preventative medical facilities, nutrition in industry and the recent trends in rehabilitation.

The council is open to physicians and others interested in industrial health problems, and announcement has been made that there will be no registration fee.

PNEUMONIA CONTROL BULLETIN

Dr. F. C. Beelman, Secretary of the Kansas State Board of Health recently released the following bulletin in regard to the operation of the pneumonia control program for the medically indigent pneumonia patients for the years 1942 and 1943:

"Sulfonamides will be consigned to the following stations from which the physicians may obtain such materials as needed for the treatment of their medically indigent pneumonia patients.

St. Joseph Hospital	Concordia
Lattimore Laboratories	El Dorado
Mid-West Research Laboratories	Emporia
Newman Memorial Hospital	Emporia
Mercy Hospital	Independence
St. John's Hospital	Iola
Lawrence Memorial Hospital	Lawrence
St. Mary's Hospital	Manhattan
Wilson County Hospital	Neodesha
Ransom Memorial Hospital	Ottawa
Mt. Carmel Hospital	Pittsburg
St. Anthony Memorial Hospital	Sabetha
St. John's Hospital	Salina
St. Francis Hospital	Topeka
St. Francis Hospital	Wichita
Wesley Hospital	Wichita

"The following procedure should be used by the physicians in obtaining the benefits of the Pneumonia Control Program for his medically indigent pneumonia patients.

LABORATORY SERVICES

"It is requested that all cases of pneumonia be typed at the time or before drug administration. Tests will be authorized during the period when the patient is receiving specific treatment, as follows:

1. Typing of sputum (including typing of other body fluids or exudates). If pneumococci are not present, an attempt to identify the predominating organism will be made.

2. Blood culture.

3. Blood counts.

- (a) A complete hemogram at the first examination.
- (b) Hemoglobin determinations and leukocyte counts (or differential counts) every forty-eight hours.
- (c) Erythrocyte counts and differential counts when indicated by significant reductions in the hemoglobin and leukocytes, respectively.

4. Urinalyses.

- (a) A complete urinalysis at the first examination.
- (b) Examination for blood every forty-eight hours, and more complete analyses if indicated or requested.

5. Blood sulfapyridine or sulfathiazole level determinations.

Containers for specimens will be furnished upon request.

"County medical societies will recommend laboratories to be approved for the control program. The fee schedule is as follows:

Typing

(1) Neufeld	\$ 1.00
(2) Mouse	2.00
Complete blood count	2.00
(Red, white, differential, hemoglobin)	
Complete Urinalysis	1.00
Blood concentration for sulfonamides	2.00
Blood culture	1.00
White count	1.00
Hemoglobin .....	.50
Maximum amount allowed for laboratory work for any case	10.00

"This year a list of the available types of therapeutic sera obtainable for use in the Pneumonia Control Program will be given the Kansas State Board of Health each week. If the pneumonia stations will call in, giving the type of serum desired for the patient, we will advise them accordingly.

"Typing sera will be furnished by the Public Health Laboratories as in previous years, as will sulfonamides.

"The Kansas State Board of Health will then pay for the serum used and the laboratory services rendered for the indigent patients for whom the State Board of Health has received complete case records. In order to obtain the benefits of this program and receive payment, each patient must have a set of four cards complete in every detail giving the history of his case, as follows:

CASE REPORT CARD NO. 1—The case report card is filled in by the physician and signed to show the outcome of the case. The principal reason for this card is to show how much drugs have been used on the patient. The amount of serum used on the indigent patient must also be stated on this card.

SERVICE REQUEST FORM NO II—Before any drugs are released, this card should be signed by the doctor showing that the patient is medically indigent.

MATERIALS ISSUED CARD NO. III—This card is filled in by the person in charge of the therapeutic materials. When a doctor requests certain drugs, the nurse fills in this card and the doctor signs the card before the drugs are released.

REPORT OF LABORATORY EXAMINATIONS NO. IV—This card is filled in by the laboratory making the examinations. From this card the vouchers are written to pay for all the laboratory services rendered.

"When the case is closed, all four cards should be as-

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sembled and mailed to the Kansas State Board of Health, where vouchers will be prepared to pay for laboratory services rendered.

MINUTES

The following members of the Society Committee on Scientific Work were present at a meeting of that organization held in Topeka on September 27: Dr. Henry N. Tihen of Wichita, President, Dr. Ralph I. Canuteson of Lawrence, Dr. J. A. Blout of Larned, Dr. T. P. Butcher of Emporia, Dr. Harold E. Morgan of Newton, Dr. R. M. Isenberger of Kansas City and Dr. Thomas T. Meyer of Marysville. Others present were: Chancellor Dean W. Malott of Lawrence, Dean H. R. Wahl of Kansas City, Dr. L. A. Calkins of Kansas City, Dr. F. C. Beelman of Topeka, Dr. Ray A. West of Wichita, Dr. J. L. Lattimore of Topeka, Dr. Paul E. Belknap of Topeka, Dr. C. H. Lerrigo of Topeka, Dr. Fred J. McEwen of Wichita, Dr. Philip W. Morgan of Emporia and Miss Jane Skinner, Assistant Executive Secretary.

The following are the minutes of the meeting:

"The meeting was called to order by Dr. Tihen to discuss the needs of post-graduate medicine for the State of Kansas. He presented the following suggestions:

"1. The importance of cooperation between the State Board of Health, the University of Kansas, and The Kansas Medical Society.

"2. That it would be necessary to have post-graduate program in working shape by the time the crisis is over.

"3. Type of organization and whether authority should be divested in one person or in a committee.

"4. The necessity of studying post-graduate medical courses in other states.

"Chancellor Malott, of the University of Kansas, emphasized the need of adult education. He reported that the University of Kansas would cooperate fully with all the institutions to set up this course. He stressed the importance of post-graduate medicine during the war crisis as well as after the crisis. He gave a brief summary of the work of the extension division of the University and offered the services of that branch in setting up this course.

"Dean Wahl, of the University of Kansas School of Medicine, stated that the Medical School would be glad to cooperate by contributing the time of members of the staff to go out for circuit courses but stated that there was not space in the hospital at the present time to hold classes. The only time space could be available would be during vacations. He also stressed the fact that instruction now as well as later was very important to the doctors of medicine.

"A student union building at the Medical School was discussed and Chancellor Malott stated that the 1941 Legislature has approved such a building but that it was impossible to build during the present crisis.

"Dr. Philip Morgan, Chairman of the Committee on the Study of Heart Disease, reported the steps his committee has taken in the study of the heart and how the committee had built up the interest of the doctors by bringing in noted heart specialists and that he thought the aim of his committee had been successful.

"Dr. Calkins discussed the length of the courses and the fact that we would be able to get financial aid from the State Board of Health to set up the post-graduate courses. He stressed the necessity of setting up these courses now.

"Dr. Beelman stated that the money would be available through the United States Public Health Service for the

physicians to travel to the center for education and also resources for the establishment of a center.

"Dr. Lattimore discussed the necessity for the medical profession and the University of Kansas Medical School to work closer together on this subject.

"Dr. Lerrigo discussed the work of the Committee on Control of Tuberculosis and what they had accomplished by study and lectures and the progress made in the last few years. He suggested the plan his committee had followed would be of aid in setting up post-graduate medical courses.

"Dr. Canuteson reported the progress his committee had made in securing data on post-graduate medicine in other states. He had compiled the information that he had received and passed out copies to the members of the committee and guests.

"Further discussion of the above matters followed.

"Adjournment followed."

A meeting of the Society Committee on Industrial Medicine was held in Wichita, on November 7, Dr. Charles R. Rombold, Chairman, presiding. Members present were: Dr. James L. Beaver, of Wichita; Dr. C. E. McCarty, of Dodge City; Dr. J. R. Betthausen, of Hays; Dr. G. E. Kassebaum, of Eldorado; Dr. A. E. Hiebert, of Wichita; Dr. Orlen J. Johnson of Chicago, Illinois; and Dr. R. M. Heilman, Director of the Industrial Health Division of the Kansas State Board of Health of Topeka, were also present.

The Chairman opened the meeting by introducing Dr. Orlen J. Johnson, of the Chicago American Medical Association office who is making a tour of the states in the interest of industrial health programs. Dr. Johnson opened his discussion by stating that we were now faced with a situation in industrial health which is vitally important to the war effort and to the future of medicine. A short time ago Director McNutt stated to the American Medical Association that the medical needs of small industry and of some large industries had not been met, and that they must be, or the government will step in and see that they are met. We must, continued Dr. Johnson, educate the doctors in the procedure to reduce absenteeism and doctors themselves must organize and function to bring about such a reduction in order that the American Medical Association can say to the federal government that there is no necessity for their stepping in and taking charge of the industrial health program because the medical profession is meeting the need adequately. At the present time this assertion cannot be made.

The industrialists are not now aware of the situation and an industrial health program cannot be started without the active aid of our industrialists.

The greatest causes of absenteeism in industry are the same as for the rest of the civilian population. Some plants have already developed plans that are successful and these plans can be drawn upon. The State Society is being asked to formulate plans among their men and see that these plans are carried out. Springfield, Vermont and Williamsport, Pennsylvania have excellent plans. In Springfield, Vermont the medical profession was approached and asked to help in an industrial health program. A plan for a rotating staff was set up and taken to each industrial plant. In Williamsport a committee was formed to advise the industrialists as to which doctors were available for use in their plants. No rotation of physicians was involved in this plan. In Philadelphia a plan involving a clinic with nurses

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for taking care of a group of plants was set up, but is not considered as desirable as some of the other plans. In Iowa a series of Industrial Health Institutes was sponsored by the state society. A team of speakers was formed, which would travel from city to city holding institutes. The plan which has been used in California is somewhat comparable to the Iowa plan. In Kentucky a plan in cooperation with the War Manpower Committee has been developed. This is organized to present educational programs in four different fields, namely, medical service, safety, engineering, and welfare. A plan in Connecticut has been evolved in cooperation with the American Medical Association and the National Association of Manufacturers.

The Bureau of Industrial Hygiene is a most valuable adjunct to the work of developing a full time program.

The first problem confronting this Committee, said Dr. Johnson, is the formation of local committees to cooperate in putting into effect the plan or program decided upon. The Iowa plan or some other special type of program could be used advantageously. Institutes could be held that would be of great value.

The Chairman then asked Dr. Johnson to explain the nature of the Iowa institute.

Replying, Dr. Johnson stated that these sessions would start at 2:30 in the afternoon. Several twenty minute papers would be presented outlining different phases of the program. The bureau of Industrial Hygiene would discuss the problem throughout the state and set forth the type of medical service needed in various industries. Other papers would be presented on topics such as compensation and cost, nutrition, absenteeism and control, women in industry, fatigue and hours of work, use of sub-standard workers, etc. It also had proved quite beneficial to have an industrialist who had had experience with some such program to discuss benefits to the "boss".

In reply to Dr. Rombold's question as to whether a program of four or five speakers presented in different counties in the evening only would suffice, Dr. Johnson stated that he believed it would be most beneficial if the county society would devote one regular meeting per year to industrial health other than injuries.

Dr. Rombold was of the opinion that through the State Society, all industrial centers could be adequately covered.

Dr. Johnson continued that Iowa set up a series of meetings, and that nationally known men were invited to speak. Such meetings were attended by far more industrialists than medical men. This also was true in Illinois where the manufacturers cooperated by widely publicizing the meeting. In California the industrialists, especially personnel men, attended in large numbers. Many doctors were prone to stay away from the meetings because of their heavy load of work. It is, therefore, necessary that this program be taken to them, that they be urged to attend. Dr. Kassebaum then asked as to whether the program was intended more for the doctors or for the industrialists. In reply, Dr. Johnson stated that it was for the doctors, but the industrialists must be interested and informed if the program is to succeed. Others interested in the program are insurance companies, nurses, health departments, nutritionists, etc. It should not of necessity be made an entirely technical conference.

Dr. Rombold was of the opinion that the Wichita doctors alone would not support such a meeting and that it would be much better to put the program on before the county society and others should be invited to attend. Dr. Johnson acknowledged that programs must be adapted to local conditions following individual community characteristics, etc.

Dr. Kassebaum stated that he believed that lack of time and not so much a matter of lack of interest would tend to keep doctors away from the meetings.

Dr. Johnson then continued his discussion by pointing out that the profession was faced with two problems, one immediate and the other long range. After the war industrial health programs will be larger than ever. Some states are already setting up long range programs. The point has been reached where we have to face the problem. There are those who would like to regiment medicine.

Dr. Heilman stated that if the profession does not solve the present industrial health problems it will soon find itself swamped and when that happens that the federal government will "step in and take over". If the Newton water epidemic, he continued, had happened in Wichita it would have created chaos. Public health men would swarm in and take over. The profession has been asleep to such possibilities and now is the time for them to become aroused and go to work on industrial health. This disinterest on the part of physicians is due principally to their being so busy at this time.

Dr. Kassebaum asked specifically what more the profession could do in the light of the fact that we have our public health board with doctors and nurses. He wondered if the Newton epidemic was not one for the consideration of sanitation engineers.

Dr. Johnson continued that immunization is not industry's job, but is an ideal place for the profession to step in with a definite program. Epidemics hit crowded centers. The medical profession has a greater job now than ever before. Procurement and Assignment, of course, is a definite responsibility, but equally vital is the carrying of the home load by a depleted staff at a time when people are being crowded together in industrial centers. Dr. Kassebaum asked why industrial plants did not require immunization. Dr. Johnson replied that industry is relatively new in this part of the country, that the industrialists are rugged individualists and are not aware of the advantages of such a program. One plant in Wichita in particular is totally asleep to the situation. In older industrial sections the industrialists have gone forward on their own initiative.

Chairman Rombold then asked Dr. Johnson what specific things should be included on the program. Dr. Johnson replied that every plant should have a program of industrial health commensurate with its size and needs. Medical men should familiarize themselves with the materials and processes used in various plants in order to forestall illnesses which could be caused by them. All sub-standard workers should be examined and assigned to work to which they are physically adapted and which they can carry. The doctor should carry out a program of industrial education through talks with individual workers about problems and worries. He should suggest that the worker secure medical attention to correct physical disabilities or handicaps. Such workers should then be checked periodically to see that these suggestions are being followed and that they are working in a manner which does not aggravate their physical conditions. The health program should be carried into the home in order to assure the worker and his family of proper food. Rationing in the near future may have a great effect. Women, pointed out Dr. Johnson, are big "time losers". Special attention should be given to them. Industrial health programs have reduced time lost by sub-standard workers from twenty-five to forty per cent. In initiating such a program a doctor should spend one hour a week in a plant with the assistance, if possible, of a nurse. His time should not be spent in finger wrappings, but in education and prevention. He should see that conditions in plants are



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* *Laryngoscope*, Feb. 1935, Vol. XLV, No. 2, 149-154
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60

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so controlled as to prevent loss of time. In illustrating the possibilities in controlling plant conditions, Dr. Johnson pointed out that in a plant in Pennsylvania using large quantities of Benzol the air containing Benzol fumes was being re-circulated and that in a short time due to this condition, 300 workers were in bed. Dr. Johnson pointed out that the statement was made before a medical meeting in St. Louis that within the next three months the government would step in and coordinate all industrial health work, with a coordinator appointed by the War Production Board working with assistance from the War Manpower Commission.

Dr. Rombold stated that the medical Society must first create an appetite for such a program. Dr. Beaver pointed out that such a program would cost money; that the executives are not now sold on its benefits.

Dr. Johnson then cited the instance of a DuPont plant located in Richmond, Virginia, of 3500 employing five full time doctors. This plant has had no lost time accidents in over a year, and as a consequence, is thoroughly sold on the plan. He suggested that a small start be made, such as medical service in the plant one hour a day. If you should suggest to a plant that a full-time doctor be secured you would scare them to death, although it is actually cheaper to hire a full time doctor than none. It can be shown that they will save money by spending money.

Dr. Heilman pointed out that the State of Kansas has between \$30,000 and \$40,000 worth of equipment for the detection of hazardous gases, etc. These are provided to industrialists without cost. The state also offers free service as to Wassermans, water analysis, milk analysis, nutrition, maternal welfare, etc. Replacement examinations are of great value to industrialists in the elimination of law-suits, especially in respect to diseases of the chest. He stated that he knew of one place that the labor unions were against immunization, especially for typhoid because of the discomfort of reaction. Their attitude is that "we have never had an epidemic, so why worry or take shots that cause discomfort". In reply to Dr. Kassebaum's question as to compensation for sub-standard workers Dr. Beaver pointed out that the rate for such insurance as paid by industry was based on an overall five year's experience table which was readjusted each year.

Dr. Johnson further pointed out that if a worker with an injury was placed on a job that aggravated the injury, industry had to pay. The right kind of an industrial health program will assist in placing such people where they can stand up under the load they are expected to carry.

Dr. Heilman also suggested that standards of employment should be set up: that a definite policy should be established.

Dr. Johnson brought out that an industrial health program can very well be worked out through the Manufacturers Club, the Chamber of Commerce, or Associated Industrialists.

Dr. Heilman continued that meetings should be held with the industries and members of the medical profession in order to get industry so interested that they in turn will go to their employees. The Chairman then pointed out that the Sedgwick County Medical Society has twice tried to sell one of the Wichita aircraft plants on immunization and each time has failed. Dr. Kassebaum pointed out that an applicant with high blood pressure would not be hired until that blood pressure had been definitely reduced, but plants would not do anything about immunization, which was much more vital.

It is hard for the industrialist to project himself into the future in the realization of needs and possible disaster, Dr.

Beaver pointed out, and the medical profession must combat the inexperience of the industrialist in health problems. It was brought out that the possibilities of law-suits in the future due to lack of medical precautions is tremendous. Mention was made of the fine cooperation of the Kansas Department of Labor, which will assist in the correction of bad working conditions.

The Chairman then stated that it would appear that the first job of this committee was to set up a sales program to create an appetite for an industrial health program. He then asked how finances could be secured to bring into the state outstanding speakers for such a program. Dr. Johnson replied that the State Board of Health, under Title 6 of the Social Security Act, has money available for educational purposes which could be used in securing outstanding speakers. In the state of Connecticut the Manufacturers' periodical devotes one page each issue to industrial education. In reply to the question as to what definite steps should be taken to originate such a program Dr. Johnson suggested, first, that local, or county, committees on industrial health be formed; second, that an educational program be developed, designed for the medical profession as well as for industry; third, that afternoon or evening meetings, as may be desired, be set up to include both groups, for stimulating county committees to induce county societies to devote one meeting a year entirely to this program; fourth, that local committees be activated to formulate a plan adaptable to their particular locality. He then suggested a serious consideration of the program for small industries as set forth on Page 127 of Industrial Health Bulletin Number 12, issued on April 7, 1942. This program is outlined as follows:

"Committees on Industrial Health need a basis on which to erect a sound structure of industrial health activity. The

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following outline is advanced for discussion and action:

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3. Industrial hygiene service.
4. Proper correlation of plant health activities with those of:
 - a. The practicing medical profession.
 - b. Industrial commissions.
 - c. Units of state, county and city health departments.
5. A health program to include:
 - a. Physical examinations.
 - b. Plant inspections.
 - c. Emergency stations.
 - d. Reporting.
6. Adequate compensation of health personnel.

"The Council will augment this basic outline from time to time with additional recommendations derived from the experiences of medical organizations throughout the country.

In the subsequent discussion it was suggested that Wyandotte and Sedgwick counties should have committees appointed at an early date and that there was a possibility that committees in Kansas could use the same panel of speakers as were to be used in Oklahoma. It was pointed out that public health men in Washington will cooperate all they can in furnishing speakers, films, pamphlets, etc. without cost. The Kansas State Board of Health is correct in its attitude that such a program must be set up and pushed by the local county society. The medical profession must be educated to the idea that setting up of industrial health programs is the fair and wise thing to do. The American Medical Association favors the free choice of physicians but the industrialist and the insurance company are also interested parties. The best program is one in which the worker will retain the family physician wherever possible.

It was suggested that a contact be made with the Oklahoma group in regard to the use of their program. It was also agreed that county committees should set up fee schedules and the matter should later be taken before the State Society.

It was moved by Dr. Hiebert (Kassebaum) that we encourage the formation of industrial committees in the Sedgwick and Wyandotte county medical societies to cope with the industrial health problems. The motion prevailed. The following resolution presented by Dr. Beaver (Kassebaum) was unanimously passed by the committee:

"It is the opinion of this committee that industrial health institutes should be set up in Wyandotte and Sedgwick counties, the functions of which are to set forth and emphasize the benefits and advantages of industrial health programs to industry and to acquaint physicians with the scope of this industrial health program as related to the war effort."

It was moved by Dr. Bethausen (Hiebert) that the pro-

cesses of selecting a suitable program be delegated to Dr. Heilman and the Executive Secretary; that the program be selected and presented to the members of this committee for their approval after which the chosen speakers are to be contacted. The motion prevailed.

The committee then asked Dr. Heilman to formulate a program consisting of four fifteen-minute in-state speakers to be used at other than Sedgwick and Wyandotte County Society meetings, after which the Executive Secretary would notify the county medical societies that such a program was available for their use.

There being no further business the meeting was adjourned.

COUNTY SOCIETIES

The Butler-Greenwood County Medical Society held a dinner meeting at the Allen Memorial Hospital in El Dorado on November 13. Dr. G. E. Kassebaum and Dr. Floyd E. Dillenbeck of El Dorado discussed "Infantile Paralysis".

The Saline County Medical Society held a meeting on November 12 in Salina at which Dr. Charles Rombold of Wichita and Dr. Newman Nash of Wichita spoke on "Sciatic Pain as the Result of Retroplaced Intervertebral Disc" and "Medicine by Ear".

The members of the Lyon County Medical Society held a meeting in Emporia recently and elected the following officers for the new year: Dr. D. P. Trimble of Emporia as President, Dr. C. L. Patton of Emporia as Vice-President, Dr. C. H. Munger was re-elected as Secretary-Treasurer. Dr. C. W. Lawrence, Dr. J. J. Hovorka and Dr. F. A. Eckdall all of Emporia were elected on the Board of Censors. Dr. O. J. Corbett of Emporia presented a paper entitled "Pathological Discharge from the Nipples."

The Pratt County Medical Society held a meeting on October 23 in Pratt. Speakers were Dr. Paul C. Carson of Wichita who discussed "The Kenny Treatment and Dr. Hervey R. Hobson of Wichita who spoke on "Peritonitis".

In conjunction with the Kansas Crippled Children's Commission the following medical societies have sponsored Crippled Children's Clinics in several towns in the state recently. On November 16 the Graham County Medical Society conducted a clinic at Hill City, on November 20 the Ford County Medical Society held a clinic at Dodge City and on November 27 the Pratt County Medical Society held a clinic at Pratt. Orthopaedic surgeons assisting the societies in the clinics were as follows: Dr. C. B. Francisco of Kansas City, Dr. E. D. Ebright of Wichita and Dr. F. E. Coffey of Hays.

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The Sedgwick County Medical Society held a meeting in Wichita on December 1. Speakers for the meeting were as follows: Dr. D. C. Peete, who discussed "Dietary Factor in Rheumatic Fever" Dr. William G. Gordon who spoke on "Pyelonephritis in Pregnancy" and Dr. Ralph Major who discussed "War and Disease". All of the speakers were members of the faculty of the University of Kansas School of Medicine.

The Shawnee County Medical Society held a dinner meeting and election of officers in Topeka on December 7. The following officers were installed for the year 1943: Dr. A. J. Brier as President, Dr. Paul E. Belknap as President-Elect, Dr. C. K. Shaffer as Vice-President, Dr. J. H. O'Connell as Treasurer and Dr. Leo Smith as Secretary.

The Washington County Medical Society held a meeting in Washington on November 18.

The Wyandotte County Medical Society held a meeting in Kansas City on November 17. The subject "Fracture Management for War and Civilian Casualties" was discussed by Dr. F. P. Dickson and Dr. C. B. Francisco, both of Kansas City.

MEMBERS

Announcement has recently been made of the following appointments to the position of coroner by Governor Payne H. Ratner: Dr. W. W. Weltmer of Beloit as coroner of Mitchell County to succeed Dr. R. E. Bennett who is not in military service, and of Dr. C. F. Young of Ft. Scott as coroner of Bourbon County to succeed Dr. L. L. Cooper who is also in the armed forces.

The International College of Surgeons recently an-

nounced that Dr. Joseph J. Hovorka of Emporia had been made a member of that organization.

Dr. Gladys Huscher, formerly of Concordia, has arrived safely in Africa after an uneventful crossing. Dr. Huscher has returned to her medical missionary work in Africa after a leave of absence in Kansas.

Dr. William C. Menninger of the Menninger Clinic of Topeka was commissioned as a Lieutenant Colonel in the United States Army Medical Corps on November 24. Dr. Menninger has been assigned to consulting work in the psychiatry branch of the Army and his commission is the second of its kind to be awarded in the United States.

Dr. C. C. Nesselrode of Kansas City was a speaker at the training school conducted for the Women's Field Army for Control of Cancer which was held in Abilene on November 10.

The September issue of International Medical Digest published an abstract of the article entitled "Roentgenographically Demonstrable Causes of Cyanosis in the Infant and New Born" by Dr. John F. Bowser of Kansas City, which was first published in the July, 1942, issue of the Journal.

Dr. Paul C. Carson and Dr. Hervey R. Hodson, both of Wichita, were speakers at a meeting of the Pratt County Medical Society on October 23. Dr. Carson spoke on "The Kenny Treatment" and Dr. Hobson spoke on "Peritonitis."

Dr. C. H. Lerrigo, of Topeka, was elected as President of the Mississippi Valley Tuberculosis Association at its annual conference held in Chicago recently. Dr. H. L. Hiebert of

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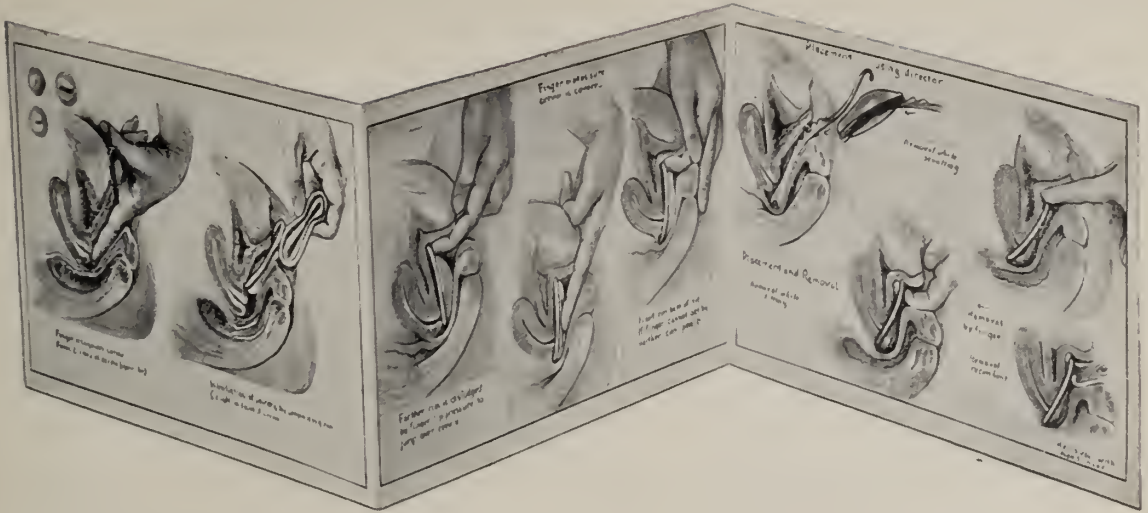
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Topeka was also elected as a member of the governing board of the organization at the meeting.

The October issue of Digest of Ophthalmology and Otolaryngology published an abstract of the article by Dr. Louis R. Haas of Pittsburg entitled "Retrolubar Neuritis" which was originally published in the June, 1942, issue of the Journal.

Dr. C. E. Partridge of Emporia attended the 14th Annual Aero-Medical Association held in Indianapolis, Indiana, recently.

Major R. W. VanDeventer, formerly of the Officers Recruiting Board of Topeka, has recently returned to Fort Warren, Wyoming.

ANNOUNCEMENTS

The Fifth Annual Forum on Allergy will be held in Cleveland, Ohio on January 9-10, 1943. Those interested in attending will please write: Dr. Jonathan Forman, 956 Bryden Road, Cleveland, Ohio for copies of the program and registration blanks.

Announcement has been received recently that the American Urological Association is offering an annual award "not to exceed \$500.00 for an essay or essays on the result of some specific clinical or laboratory research in Urology. The amount of the prize being based on the merits of the work presented and if the Committee on Scientific Award deems none of the offerings worthy, no award will be made. Competitors are limited to residents in urology in recognized hospitals and to urologists who have been in such specific practice for not more than five

years. Essays must be in the hands of the Secretary, Dr. Thomas D. Moore, 899 Madison Ave., Memphis, Tennessee on or before March 1, 1943.

A prize of \$100 is offered by the Menninger Foundation for Psychiatric Education and Research of the best suggestion for a window display in a New York bank presenting the uses and purposes of psychiatry. The window is thirteen feet long, six feet high, and its deepest point about eight feet; it curves so that it is narrower at the ends. It will be seen chiefly by laymen and hence the display should be in the nature of an educational theme, convincingly and graphically presented. It should dramatize the way in which psychiatry can be or is being useful either in the present war emergency or in peace time. The judges will be Dr. George Stevenson, Director of the National Committee for Mental Hygiene, Mr. Albert Lasker of Lord and Thomas, and Dr. Lawrence Kubie. Ideas should be submitted in detail, preferably with drawings or diagrams, directly to Dr. William C. Menninger, Director of the Menninger Foundation, Topeka, Kansas, on or before January 31, 1943.

The 17th Annual National Conference of Medical Services will be held in Chicago at the Palmer House on February 15-16, 1943. The conference is in connection with the Congress on Medical Education and Licensure, and information about the program may be secured by writing the Secretary: W. L. Burnap, M.D., Fergus Falls, Minnesota.

Announcement has been received recently of the cancellation of the 1943 Annual Session of the American College of Physicians which was scheduled to be held in Philadelphia on April 13-16.

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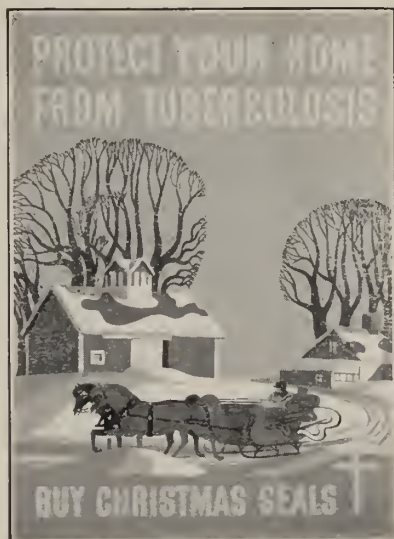
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AUXILIARY

PRESIDENT'S MESSAGE

The mid-year meeting of the Board of Directors of the Women's Auxiliary to the American Medical Association met in Chicago on November 20. In addition to the officers, directors and chairmen of standing committees, seventeen state presidents were present.

Information will soon be out regarding headquarters for the meeting of our Board and House of Delegates in Chicago in June. Reservations for the meeting should be made as soon as possible due to crowded hotel conditions in Chicago.

A handbook on Hygeia has been published and sent to all state and county Hygeia chairmen. This little booklet is most instructive and should spur us to greater efforts to meet our quota in Kansas.

The Legislative Chairman urged us to study parties and issues in politics and mentioned that we should all read an article on legislation in the September 6, 1942 issue of the American Medical Association Journal.

The Historian displayed bound volumes which are in the Archives in the American Medical Association office and I was pleased to note that Kansas had a nice section.

The Organization Chairman reported that her work was progressing very well—several new counties and one new state had been added to the roster.

The Finance Chairman reported that a \$1,000.00 Series G, Bond had been purchased with surplus funds of the Auxiliary.

Dr. W. W. Bauer spoke to us after our luncheon. He said his visits would be necessarily curtailed this year but that under certain conditions he would be able to make a few trips. If your local units are planning any local public relations meetings and would like to have him speak, please get in touch with Mrs. Leo Schaefer, our Public Relations Chairman and she will see what arrangements can be made. Dr. Bauer reported that beginning on Saturday, December 26 "Doctors at War" would be broadcast over the red network of N. B. C. at 4:00 p.m. Central War Time. This program is sponsored by the Army and Navy Departments. If your local station does not carry the program and you would like to hear it, please contact your radio station. If they have commitments at that particular time, they may be able to make a transcription of it and re-broadcast it at some other time.

We have already passed the half way mark in our year's work. Are you satisfied with what you have been able to accomplish? Let's all of us put forth a little extra effort and make this a year to be proud of.

Sincerely
Mrs. C. Omer West.

AUXILIARY NEWS

The Women's Auxiliary to the Mitchell County Medical Society entertained with a turkey dinner for the members of the Mitchell County Society and the nurses of the Community Hospital on November 3 at the Nurse's Home in Beloit. A business session of the county medical society was held following the dinner at which Dr. Harold Neptune of Salina, Dr. C. M. Fitzpatrick of Salina and Dr. Earl Vermillion of Salina were the guest speakers. The

Auxiliary also held a business meeting and spent some of the time assisting the Tuberculosis Control Committee of Mitchell County Christmas seals.

The Labette County Auxiliary served a luncheon to those assisting the crippled children's clinic, sponsored by the Labette County Medical Society and the Kansas Crippled Children's Association, which was held in Parsons on November 6. Dr. C. B. Francisco of Kansas City was in charge of the clinic. On October 28 the Auxiliary of the Labette County Society entertained with a dinner at the home of Dr. and Mrs. Charles Miller of Parsons.

The Women's Auxiliary to the Sedgwick County Medical Society held a Christmas luncheon in Wichita on December 14. Miss Meridith Fraker, Wichita dramatist, presented the program. A regular board meeting proceeded the luncheon.

The Shawnee County Women's Auxiliary and the Shawnee County Medical Society held a guest tea on December 14 at the home of Mrs. Paul M. Powell. The wives of the staff members of the hospital at the Topeka Bomber Base and Mrs. C. Omer West, State President of the Auxiliary of Kansas City, were the guests. Mrs. J. F. Casto was in charge of the music for the program. Assisting hostesses were Mrs. H. H. Woods, Mrs. O. A. McDonald, Mrs. R. E. Pfuetze, Mrs. S. T. Millard and Mrs. James Bowen.

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"Peace on Earth, Good Will Toward Men"

It may seem ironical to quote those familiar words at a time when the earth is ablaze with war; yet implicit in their beauty is the very essence of that for which we are fighting . . . This war is not of our making, not of our choosing. We are in it because the principles in which we believe are threatened with annihilation, and because deep down in our national conscience we know that our way of life, for all its shortcomings, is the practical as well as the idealistic approach to "Peace on Earth, Good Will toward Men" . . . There are cynics who argue that there will always be war, that it is man's nature to fight man; but their reasoning is specious. Had Ehrlich, for instance, lacked the faith and incentive to persevere, had he been discouraged by six hundred and five unsuccessful experiments, 606 might never have been discovered and the chances are that one of man's greatest scourges would still be uncontrollable . . . In our great struggle, we of the United Nations derive strength and courage from a sublime faith in our cause. Our conscience is clear and unafraid. In the laboratory of World Events we are using all of our spiritual and physical resources to discover the formula that once and for all will put an end to the scourge of war. Please God, at this Yuletide, that we may soon find that formula through Victory, so that our children and their children and the generations to come may know the full glory and meaning of "Peace on Earth, Good Will toward Men."

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ADVERTISING NEWS

During the past year, Eli Lilly and Company of Indianapolis, Indiana, have produced three 16 mm silent motion pictures in color, describing certain vitamin deficiency diseases, which have been in constant demand for showing before medical groups under sponsorship of a physician. One of the films deals with the deficiency of thiamine chloride (beriberi), another with nicotinic acid deficiency (pellagra), and the third with ariboflavinosis. To meet the great demand additional films have been made and are now ready for loan. The major part of all films concerns the clinical picture presented by the patient with reference to treatment by diet and specific medication but they do not contain advertising of any description. The films were made at the Nutritional Clinic of the University of Cincinnati at the Hillman Hospital, Birmingham, Alabama, where studies were initiated in 1935, under the joint auspices of the Department of Internal Medicine of the University of Cincinnati and the University Hospitals of Cleveland. Subsequently, these investigations become a co-operative project between the Departments of Medicine of the University of Cincinnati and the University of Alabama, and the Department of Preventive Medicine and Public Health of the University of Texas.

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